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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141301	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/29/2016 11:00 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/29/2016 Time: 11:00 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by KIRBY HOSPITAL (141301) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	147,379	-84,762	654,613	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	314,752	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		14,256		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-7,573		0	10.01
200.00	Total	0	462,131	-78,079	654,613	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2016 10:55 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 MEDICAL CENTER DRIVE	PO Box:			1.00
2.00	City: MONTICELLO	State: IL	Zip Code: 61856	County: PIATT	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	KIRBY HOSPITAL	141301	16580	1	08/08/1999	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	KIRBY HOSPITAL - SWING BED	14Z301	16580		08/08/1999	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	ATWOOD RURAL HEALTH CLINIC	143438	16580		11/17/1997	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	KIRBY MEDICAL GROUP RHC	143495	16580		11/20/2008	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2015	06/30/2016	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2016 10:55 am

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2016 10:55 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2016 10:55 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141301	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/29/2016 10:55 am

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	75,249	0	0	118.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/29/2016 10:55 am

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141301	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/29/2016 10:55 am

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	667,972	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2014	09/30/2015	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 11/29/2016 10:55 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	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)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/03/2016	Y	10/03/2016 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 11/29/2016 10:55 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 141301	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/29/2016 10:55 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/29/2016 10:55 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	16	5,856	12,768.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		16	5,856	12,768.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		16	5,856	12,768.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		16				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/29/2016 10:55 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	312	15	532			1.00
2.00	HMO and other (see instructions)	123	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	690	0	1,160			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	360			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,002	15	2,052			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,002	15	2,052	0.00	175.64	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	395	0	3,486	0.00	5.50	26.00
26.01	RURAL HEALTH CLINIC II	3,061	0	17,261	0.00	25.25	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	206.39	27.00
28.00	Observation Bed Days		0	102			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/29/2016 10:55 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	99	6	170	1.00
2.00	HMO and other (see instructions)			36	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	99	6	170	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

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

Provider CCN: 141301 Component CCN: 143438 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-8 Date/Time Prepared: 11/29/2016 10:55 am

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	108 SOUTH MAIN STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ATWOOD	IL	61913	2.00

		1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	16:30	08:00	11.00

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

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

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	12:00	08:00	16:30	08:00	16:30	11.00

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

Provider CCN: 141301
Component CCN: 143438

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-8
Date/Time Prepared:
11/29/2016 10:55 am

Rural Health Clinic (RHC) I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	16:30				11.00

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

Provider CCN: 141301 | Component CCN: 143495 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-8 | Date/Time Prepared: 11/29/2016 10:55 am

		Rural Health Clinic (RHC) II	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1000 MEDICAL CENTER DRIVE	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MONTICELLO	IL	61856	2.00

		1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			07:00	18:00	07:00	11.00

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

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

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	18:00	07:00	18:00	07:00	18:00	11.00

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

Provider CCN: 141301
Component CCN: 143495

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-8
Date/Time Prepared:
11/29/2016 10:55 am

Rural Health Clinic (RHC) II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	07:00	16:00	08:00	12:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-10 | Date/Time Prepared: 11/29/2016 10:55 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.415447	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,600,286	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	8,426,258	6.00
7.00	Medicaid cost (line 1 times line 6)	3,500,664	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	900,378	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	900,378	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	137,624	3,816,931	3,954,555	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	57,175	1,585,733	1,642,908	21.00
22.00	Partial payment by patients approved for charity care	7,645	79,852	87,497	22.00
23.00	Cost of charity care (line 21 minus line 22)	49,530	1,505,881	1,555,411	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,047,105	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	164,550	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	882,555	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	366,655	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,922,066	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,822,444	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/29/2016 10:55 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,534,967	3,534,967	64,934	3,599,901	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,049,923	1,049,923	20,679	1,070,602	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	-11,625	-11,625	26,270	14,645	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,448,422	3,527,468	5,975,890	177,996	6,153,886	5.00
6.00	00600	MAINTENANCE & REPAIRS	232,887	269,440	502,327	0	502,327	6.00
7.00	00700	OPERATION OF PLANT	0	356,726	356,726	413	357,139	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	54,443	54,443	8.00
9.00	00900	HOUSEKEEPING	270,927	141,405	412,332	-25	412,307	9.00
10.00	01000	DIETARY	320,148	251,387	571,535	-494,323	77,212	10.00
11.00	01100	CAFETERIA	0	0	0	492,851	492,851	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	98,911	29,077	127,988	0	127,988	14.00
15.00	01500	PHARMACY	47,245	241,683	288,928	0	288,928	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	527,806	218,904	746,710	0	746,710	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,332,354	671,597	2,003,951	-22,122	1,981,829	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	366,171	650,806	1,016,977	-5,508	1,011,469	50.00
53.00	05300	ANESTHESIOLOGY	129,732	28,143	157,875	0	157,875	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	699,973	877,222	1,577,195	-5,338	1,571,857	54.00
56.00	03630	ULTRA SOUND	0	52,099	52,099	0	52,099	56.00
60.00	06000	LABORATORY	536,860	1,129,516	1,666,376	-2,103	1,664,273	60.00
66.00	06600	PHYSICAL THERAPY	499,327	178,380	677,707	-2,678	675,029	66.00
67.00	06700	OCCUPATIONAL THERAPY	166,164	40,909	207,073	0	207,073	67.00
68.00	06800	SPEECH PATHOLOGY	0	29,348	29,348	0	29,348	68.00
69.00	06900	ELECTROCARDIOLOGY	17,270	4,285	21,555	11,942	33,497	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	63,265	63,265	0	63,265	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	66,246	66,246	0	66,246	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	321,072	321,072	0	321,072	73.00
76.00	03950	SLEEP LAB	76,935	120,615	197,550	-1,708	195,842	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	305,665	156,179	461,844	-56,280	405,564	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,571,125	902,518	2,473,643	-195,237	2,278,406	88.01
91.00	09100	EMERGENCY	867,451	2,144,309	3,011,760	-23,195	2,988,565	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	252,059	158,919	410,978	-560	410,418	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,767,432	17,204,783	27,972,215	40,451	28,012,666	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	FOUNDATION	66,372	48,384	114,756	-14,181	100,575	190.01
190.02	19002	CROSSFIT	20,707	20,129	40,836	-26,270	14,566	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118-199)	10,854,511	17,273,296	28,127,807	0	28,127,807	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/29/2016 10:55 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-140,206	3,459,695		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-222,572	848,030		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	14,645		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-604,442	5,549,444		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	502,327		6.00
7.00	00700	OPERATION OF PLANT	10,226	367,365		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	54,443		8.00
9.00	00900	HOUSEKEEPING	0	412,307		9.00
10.00	01000	DIETARY	0	77,212		10.00
11.00	01100	CAFETERIA	-161,821	331,030		11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	127,988		14.00
15.00	01500	PHARMACY	0	288,928		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-307	746,403		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-178,527	1,803,302		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-149,849	861,620		50.00
53.00	05300	ANESTHESIOLOGY	-75,026	82,849		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-243,157	1,328,700		54.00
56.00	03630	ULTRA SOUND	0	52,099		56.00
60.00	06000	LABORATORY	0	1,664,273		60.00
66.00	06600	PHYSICAL THERAPY	-100,317	574,712		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	207,073		67.00
68.00	06800	SPEECH PATHOLOGY	0	29,348		68.00
69.00	06900	ELECTROCARDIOLOGY	-17,270	16,227		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	63,265		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	66,246		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	321,072		73.00
76.00	03950	SLEEP LAB	-86,726	109,116		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	405,564		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,278,406		88.01
91.00	09100	EMERGENCY	-802,024	2,186,541		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-58,208	352,210		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,830,226	25,182,440		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	FOUNDATION	0	100,575		190.01
190.02	19002	CROSSFIT	0	14,566		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,746	11,746		192.00
200.00		TOTAL (SUM OF LINES 118-199)	-2,818,480	25,309,327		200.00

RECLASSIFICATIONS | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/29/2016 10:55 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	83,559	1.00
2.00		0.00	0	0	2.00
	0		0	83,559	
	B - CAPITAL LEASE INTEREST EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,054	1.00
	0		0	2,054	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	276,073	216,778	1.00
	0		276,073	216,778	
	D - EKG				
1.00	ELECTROCARDIOLOGY	69.00	9,484	2,458	1.00
2.00		0.00	0	0	2.00
	0		9,484	2,458	
	E - RHC ADMITTING				
1.00	ADMINISTRATIVE & GENERAL	5.00	208,703	41,627	1.00
2.00		0.00	0	0	2.00
	0		208,703	41,627	
	F - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	54,443	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
	0		0	54,443	
	G - CROSSFIT EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	13,321	12,949	1.00
	TOTALS		13,321	12,949	
	H - FOUNDATION REVERSE OVERHEAD ALLOC				
1.00	ADMINISTRATIVE & GENERAL	5.00	10,792	2,487	1.00
2.00	OPERATION OF PLANT	7.00	0	413	2.00
3.00	HOUSEKEEPING	9.00	380	109	3.00
	TOTALS		11,172	3,009	
500.00	Grand Total: Increases		518,753	416,877	500.00

RECLASSIFICATIONS | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/29/2016 10:55 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	83,559	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	83,559			
	B - CAPITAL LEASE INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,054	11		1.00
	0		0	2,054			
	C - CAFETERIA						
1.00	DIETARY	10.00	276,073	216,778	0		1.00
	0		276,073	216,778			
	D - EKG						
1.00	LABORATORY	60.00	1,631	472	0		1.00
2.00	EMERGENCY	91.00	7,853	1,986	0		2.00
	0		9,484	2,458			
	E - RHC ADMITTING						
1.00	RURAL HEALTH CLINIC	88.00	46,921	9,359	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	161,782	32,268	0		2.00
	0		208,703	41,627			
	F - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	514	0		1.00
2.00	DIETARY	10.00	0	1,472	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	22,122	0		3.00
4.00	OPERATING ROOM	50.00	0	5,508	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,338	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	2,678	0		6.00
7.00	SLEEP LAB	76.00	0	1,708	0		7.00
8.00	RURAL HEALTH CLINIC II	88.01	0	1,187	0		8.00
9.00	EMERGENCY	91.00	0	13,356	0		9.00
10.00	AMBULANCE SERVICES	95.00	0	560	0		10.00
	0		0	54,443			
	G - CROSSFIT EMPLOYEE BENEFITS						
1.00	CROSSFIT	190.02	13,321	12,949	0		1.00
	TOTALS		13,321	12,949			
	H - FOUNDATION REVERSE OVERHEAD ALLOC						
1.00	FOUNDATION	190.01	11,172	3,009	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		11,172	3,009			
500.00	Grand Total: Decreases		518,753	416,877			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 11/29/2016 10:55 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	349,650	0	0	0	0	1.00
2.00	Land Improvements	4,812,286	2,151,016	0	2,151,016	519,017	2.00
3.00	Buildings and Fixtures	16,177,961	273,740	0	273,740	18,111	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	10,331,222	251,531	0	251,531	65,992	5.00
6.00	Movable Equipment	6,133,461	956,114	0	956,114	481,640	6.00
7.00	HIT designated Assets	2,898,832	171,952	0	171,952	0	7.00
8.00	Subtotal (sum of lines 1-7)	40,703,412	3,804,353	0	3,804,353	1,084,760	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	40,703,412	3,804,353	0	3,804,353	1,084,760	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	349,650	0	1.00
2.00	Land Improvements	6,444,285	0	2.00
3.00	Buildings and Fixtures	16,433,590	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	10,516,761	0	5.00
6.00	Movable Equipment	6,607,935	0	6.00
7.00	HIT designated Assets	3,070,784	0	7.00
8.00	Subtotal (sum of lines 1-7)	43,423,005	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	43,423,005	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 11/29/2016 10:55 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,925,111	0	1,609,856	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,049,923	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,975,034	0	1,609,856	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3,534,967	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,049,923	2.00
3.00	Total (sum of lines 1-2)	0	4,584,890	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 11/29/2016 10:55 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	33,744,286	0	33,744,286	0.777106	64,934	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,678,719	0	9,678,719	0.222894	18,625	2.00
3.00	Total (sum of lines 1-2)	43,423,005	0	43,423,005	1.000000	83,559	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	64,934	1,925,111	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	18,625	827,530	0	2.00
3.00	Total (sum of lines 1-2)	0	0	83,559	2,752,641	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,469,650	64,934	0	0	3,459,695	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,875	18,625	0	0	848,030	2.00
3.00	Total (sum of lines 1-2)	1,471,525	83,559	0	0	4,307,725	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/29/2016 10:55 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-140,206	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-179	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,520	OPERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,491,433			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-161,821	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-307	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-222,393	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-39,946	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/29/2016 10:55 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS INCOME - AMBULANCE	B	-58,208	AMBULANCE SERVICES	95.00	0	33.01
33.02	CANCER CLINIC INCOME	B	-18,755	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PHASE III CARDIAC REHAB INCOME	B	-98,137	PHYSICAL THERAPY	66.00	0	33.03
33.04	NON-ALLOWABLE ADVERTISING	A	-87,159	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	NON-ALLOWABLE LOBBYING	A	-8,063	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PROPERTY TAX	A	-17,458	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MEDICAID ASSESSMENT TAX	A	-250,735	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	KEY EMPLOYEE LIFE INSURANCE	A	-4,275	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	TRUST DEPR HOSPITAL ADMINISTRATION	A	6,459	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	TRUST DEPR OPERATION OF PLANT	A	11,746	OPERATION OF PLANT	7.00	0	33.10
33.11	TRUST DEPR PHYSICIAN PRIVATE OFFICES	A	11,746	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.11
33.13	NON-ALLOWABLE CRNA COSTS	A	-63,326	ANESTHESIOLOGY	53.00	0	33.13
33.14	NON-ALLOWABLE DONATION EXPENSE	A	-184,510	ADMINISTRATIVE & GENERAL	5.00	0	33.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,818,480				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 11/29/2016 10:55 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	178,527	178,527	0	0	0	1.00
2.00	50.00	OPERATING ROOM	149,849	149,849	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	11,700	11,700	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	243,157	243,157	0	0	0	4.00
5.00	66.00	PHYSICAL THERAPY	2,180	2,180	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	17,270	17,270	0	0	0	6.00
7.00	76.00	SLEEP LAB	86,726	86,726	0	0	0	7.00
8.00	91.00	EMERGENCY	1,814,314	802,024	1,012,290	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			2,503,723	1,491,433	1,012,290		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	76.00	SLEEP LAB	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	178,527		1.00
2.00	50.00	OPERATING ROOM	0	0	0	149,849		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	11,700		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	243,157		4.00
5.00	66.00	PHYSICAL THERAPY	0	0	0	2,180		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	17,270		6.00
7.00	76.00	SLEEP LAB	0	0	0	86,726		7.00
8.00	91.00	EMERGENCY	0	0	0	802,024		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,491,433		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/29/2016 10:55 am

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					49	1.00
2.00	Line 1 multiplied by 15 hours per week					735	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					122	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.58	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	451.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.14	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.07	36.07	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
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, line 10)					32,571	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					32,571	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					32,571	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					72.14	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					53,023	22.00
23.00	Total salary equivalency (see instructions)					53,023	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					4,401	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					4,401	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					681	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					5,082	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					5,082	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/29/2016 10:55 am

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	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	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.14	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	53,023	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	5,082	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	58,105	63.00
64.00	Total cost of outside supplier services (from your records)	29,348	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	4,401	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	681	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	5,082	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	681	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	681	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/29/2016 10:55 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,459,695	3,459,695				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	848,030		848,030			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,645	0	0	14,645		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,549,444	238,376	72,955	3,586	5,864,361	5.00
6.00	00600	MAINTENANCE & REPAIRS	502,327	13,060	10,406	315	526,108	6.00
7.00	00700	OPERATION OF PLANT	367,365	695,055	53,140	0	1,115,560	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	54,443	15,285	0	0	69,728	8.00
9.00	00900	HOUSEKEEPING	412,307	57,514	652	366	470,839	9.00
10.00	01000	DIETARY	77,212	121,123	31,682	60	230,077	10.00
11.00	01100	CAFETERIA	331,030	56,885	0	373	388,288	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	127,988	61,142	1,894	134	191,158	14.00
15.00	01500	PHARMACY	288,928	46,002	0	64	334,994	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	746,403	74,880	14,495	713	836,491	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,803,302	464,176	57,664	1,800	2,326,942	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	861,620	315,094	76,543	495	1,253,752	50.00
53.00	05300	ANESTHESIOLOGY	82,849	0	0	175	83,024	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,328,700	176,944	312,268	946	1,818,858	54.00
56.00	03630	ULTRA SOUND	52,099	6,095	49,177	0	107,371	56.00
60.00	06000	LABORATORY	1,664,273	66,995	45,690	723	1,777,681	60.00
66.00	06600	PHYSICAL THERAPY	574,712	208,724	14,549	675	798,660	66.00
67.00	06700	OCCUPATIONAL THERAPY	207,073	0	0	224	207,297	67.00
68.00	06800	SPEECH PATHOLOGY	29,348	0	0	0	29,348	68.00
69.00	06900	ELECTROCARDIOLOGY	16,227	0	0	36	16,263	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	63,265	0	0	0	63,265	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	66,246	0	0	0	66,246	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	321,072	0	0	0	321,072	73.00
76.00	03950	SLEEP LAB	109,116	74,976	9,309	104	193,505	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	405,564	29,942	2,727	350	438,583	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,278,406	370,963	14,473	1,904	2,665,746	88.01
91.00	09100	EMERGENCY	2,186,541	304,500	19,913	1,161	2,512,115	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	352,210	41,890	60,493	341	454,934	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	25,182,440	3,439,621	848,030	14,545	25,162,266	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,237	0	0	15,237	190.00
190.01	19001	FOUNDATION	100,575	4,837	0	90	105,502	190.01
190.02	19002	CROSSFIT	14,566	0	0	10	14,576	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,746	0	0	0	11,746	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	25,309,327	3,459,695	848,030	14,645	25,309,327	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/29/2016 10:55 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,864,361					5.00
6.00	00600	MAINTENANCE & REPAIRS	158,668	684,776				6.00
7.00	00700	OPERATION OF PLANT	336,440	148,354	1,600,354			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,029	3,263	9,851	103,871		8.00
9.00	00900	HOUSEKEEPING	141,999	12,276	37,065	776	662,955	9.00
10.00	01000	DIETARY	69,388	25,853	78,058	2,804	32,904	10.00
11.00	01100	CAFETERIA	117,103	12,142	36,660	0	15,453	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	57,651	13,050	39,403	0	16,610	14.00
15.00	01500	PHARMACY	101,030	9,819	29,646	0	12,497	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	252,276	15,982	48,257	0	20,342	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	701,778	99,074	299,141	42,404	126,095	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	378,117	67,254	203,064	10,469	85,598	50.00
53.00	05300	ANESTHESIOLOGY	25,039	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	548,546	37,767	114,033	10,624	48,068	54.00
56.00	03630	ULTRA SOUND	32,382	1,301	3,928	0	1,656	56.00
60.00	06000	LABORATORY	536,127	14,300	43,175	0	18,200	60.00
66.00	06600	PHYSICAL THERAPY	240,866	44,550	134,514	5,001	56,702	66.00
67.00	06700	OCCUPATIONAL THERAPY	62,518	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,851	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,905	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,080	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,979	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	96,831	0	0	0	0	73.00
76.00	03950	SLEEP LAB	58,359	16,003	48,319	3,371	20,368	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	132,271	6,391	0	0	8,134	88.00
88.01	08801	RURAL HEALTH CLINIC II	803,950	79,179	239,070	1,847	100,775	88.01
91.00	09100	EMERGENCY	757,624	64,993	196,237	25,547	82,720	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	137,203	8,941	26,996	1,028	11,380	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,820,010	680,492	1,587,417	103,871	657,502	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,595	3,252	9,820	0	4,139	190.00
190.01	19001	FOUNDATION	31,818	1,032	3,117	0	1,314	190.01
190.02	19002	CROSSFIT	4,396	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,542	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,864,361	684,776	1,600,354	103,871	662,955	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/29/2016 10:55 am

		Cost Center Description	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	439,084					10.00
11.00	01100	CAFETERIA	0	569,646				11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,638	330,510			14.00
15.00	01500	PHARMACY	0	4,603	496	493,085		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	57,716	1,509	0	1,232,573	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	439,084	101,622	9,773	0	157,769	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	29,705	35,790	0	71,243	50.00
53.00	05300	ANESTHESIOLOGY	0	1,694	108	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	55,110	7,303	0	58,424	54.00
56.00	03630	ULTRA SOUND	0	0	2,131	0	13,312	56.00
60.00	06000	LABORATORY	0	52,374	99,726	0	210,154	60.00
66.00	06600	PHYSICAL THERAPY	0	30,400	1,831	0	62,122	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,033	3	0	986	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	370	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	59	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	14,818	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	15,516	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	75,200	493,085	0	73.00
76.00	03950	SLEEP LAB	0	7,122	1,385	0	9,614	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	9,024	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	109,655	46,959	0	4,807	88.01
91.00	09100	EMERGENCY	0	45,643	7,214	0	578,939	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	46,077	1,487	0	64,833	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	439,084	563,392	330,332	493,085	1,232,573	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	FOUNDATION	0	2,389	2	0	0	190.01
190.02	19002	CROSSFIT	0	3,865	176	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	439,084	569,646	330,510	493,085	1,232,573	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/29/2016 10:55 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,303,682	0	4,303,682		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,134,992	0	2,134,992		50.00
53.00	05300	ANESTHESIOLOGY	109,865	0	109,865		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,698,733	0	2,698,733		54.00
56.00	03630	ULTRA SOUND	162,081	0	162,081		56.00
60.00	06000	LABORATORY	2,751,737	0	2,751,737		60.00
66.00	06600	PHYSICAL THERAPY	1,374,646	0	1,374,646		66.00
67.00	06700	OCCUPATIONAL THERAPY	279,837	0	279,837		67.00
68.00	06800	SPEECH PATHOLOGY	38,569	0	38,569		68.00
69.00	06900	ELECTROCARDIOLOGY	21,227	0	21,227		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	97,163	0	97,163		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	101,741	0	101,741		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	986,188	0	986,188		73.00
76.00	03950	SLEEP LAB	358,046	0	358,046		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	594,403	0	594,403		88.00
88.01	08801	RURAL HEALTH CLINIC II	4,051,988	0	4,051,988		88.01
91.00	09100	EMERGENCY	4,271,032	0	4,271,032		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	752,879	0	752,879		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	25,088,809	0	25,088,809		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	37,043	0	37,043		190.00
190.01	19001	FOUNDATION	145,174	0	145,174		190.01
190.02	19002	CROSSFIT	23,013	0	23,013		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,288	0	15,288		192.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	25,309,327	0	25,309,327		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/29/2016 10:55 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,912	238,376	72,955	331,243	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	13,060	10,406	23,466	0	6.00
7.00	00700	OPERATION OF PLANT	11,746	695,055	53,140	759,941	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,285	0	15,285	0	8.00
9.00	00900	HOUSEKEEPING	0	57,514	652	58,166	0	9.00
10.00	01000	DIETARY	0	121,123	31,682	152,805	0	10.00
11.00	01100	CAFETERIA	0	56,885	0	56,885	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	369	61,142	1,894	63,405	0	14.00
15.00	01500	PHARMACY	38,980	46,002	0	84,982	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,445	74,880	14,495	92,820	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,839	464,176	57,664	547,679	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	110,322	315,094	76,543	501,959	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	123,612	176,944	312,268	612,824	0	54.00
56.00	03630	ULTRA SOUND	0	6,095	49,177	55,272	0	56.00
60.00	06000	LABORATORY	16,735	66,995	45,690	129,420	0	60.00
66.00	06600	PHYSICAL THERAPY	582	208,724	14,549	223,855	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SLEEP LAB	900	74,976	9,309	85,185	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,413	29,942	2,727	35,082	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,638	370,963	14,473	388,074	0	88.01
91.00	09100	EMERGENCY	6,799	304,500	19,913	331,212	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,204	41,890	60,493	104,587	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	366,496	3,439,621	848,030	4,654,147	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,237	0	15,237	0	190.00
190.01	19001	FOUNDATION	0	4,837	0	4,837	0	190.01
190.02	19002	CROSSFIT	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,746	0	0	11,746	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	378,242	3,459,695	848,030	4,685,967	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/29/2016 10:55 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	331,243					5.00
6.00	00600	MAINTENANCE & REPAIRS	8,962	32,428				6.00
7.00	00700	OPERATION OF PLANT	19,004	7,024	785,969			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,188	155	4,838	21,466		8.00
9.00	00900	HOUSEKEEPING	8,021	581	18,204	160	85,132	9.00
10.00	01000	DIETARY	3,919	1,224	38,336	579	4,225	10.00
11.00	01100	CAFETERIA	6,614	575	18,005	0	1,984	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,256	618	19,352	0	2,133	14.00
15.00	01500	PHARMACY	5,707	465	14,560	0	1,605	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,250	757	23,700	0	2,612	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,639	4,692	146,915	8,762	16,192	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,358	3,185	99,729	2,164	10,992	50.00
53.00	05300	ANESTHESIOLOGY	1,414	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,984	1,788	56,004	2,196	6,173	54.00
56.00	03630	ULTRA SOUND	1,829	62	1,929	0	213	56.00
60.00	06000	LABORATORY	30,283	677	21,204	0	2,337	60.00
66.00	06600	PHYSICAL THERAPY	13,605	2,110	66,063	1,034	7,281	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,531	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	500	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	277	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,078	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,129	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,469	0	0	0	0	73.00
76.00	03950	SLEEP LAB	3,296	758	23,730	697	2,615	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,471	303	0	0	1,045	88.00
88.01	08801	RURAL HEALTH CLINIC II	45,410	3,750	117,412	382	12,941	88.01
91.00	09100	EMERGENCY	42,794	3,078	96,376	5,280	10,622	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,750	423	13,258	212	1,461	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	328,738	32,225	779,615	21,466	84,431	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	260	154	4,823	0	532	190.00
190.01	19001	FOUNDATION	1,797	49	1,531	0	169	190.01
190.02	19002	CROSSFIT	248	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	200	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	331,243	32,428	785,969	21,466	85,132	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/29/2016 10:55 am

		Cost Center Description	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	201,088					10.00
11.00	01100	CAFETERIA	0	84,063				11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,865	90,629			14.00
15.00	01500	PHARMACY	0	679	136	108,134		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,517	414	0	143,070	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	201,088	14,996	2,680	0	18,313	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,384	9,814	0	8,269	50.00
53.00	05300	ANESTHESIOLOGY	0	250	30	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,133	2,003	0	6,782	54.00
56.00	03630	ULTRA SOUND	0	0	584	0	1,545	56.00
60.00	06000	LABORATORY	0	7,729	27,343	0	24,393	60.00
66.00	06600	PHYSICAL THERAPY	0	4,486	502	0	7,211	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,333	1	0	114	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	43	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	16	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4,063	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,255	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	20,621	108,134	0	73.00
76.00	03950	SLEEP LAB	0	1,051	380	0	1,116	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	2,475	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	16,182	12,877	0	558	88.01
91.00	09100	EMERGENCY	0	6,736	1,978	0	67,201	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	6,800	408	0	7,525	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	201,088	83,141	90,580	108,134	143,070	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	FOUNDATION	0	352	1	0	0	190.01
190.02	19002	CROSSFIT	0	570	48	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	201,088	84,063	90,629	108,134	143,070	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/29/2016 10:55 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,000,956	0	1,000,956		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	661,854	0	661,854		50.00
53.00	05300	ANESTHESIOLOGY	1,694	0	1,694		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	726,887	0	726,887		54.00
56.00	03630	ULTRA SOUND	61,434	0	61,434		56.00
60.00	06000	LABORATORY	243,386	0	243,386		60.00
66.00	06600	PHYSICAL THERAPY	326,147	0	326,147		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,979	0	4,979		67.00
68.00	06800	SPEECH PATHOLOGY	543	0	543		68.00
69.00	06900	ELECTROCARDIOLOGY	293	0	293		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,141	0	5,141		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,384	0	5,384		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	134,224	0	134,224		73.00
76.00	03950	SLEEP LAB	118,828	0	118,828		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	46,376	0	46,376		88.00
88.01	08801	RURAL HEALTH CLINIC II	597,586	0	597,586		88.01
91.00	09100	EMERGENCY	565,277	0	565,277		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	142,424	0	142,424		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,643,413	0	4,643,413		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,006	0	21,006		190.00
190.01	19001	FOUNDATION	8,736	0	8,736		190.01
190.02	19002	CROSSFIT	866	0	866		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,946	0	11,946		192.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	4,685,967	0	4,685,967		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/29/2016 10:55 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	71,523					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		827,530				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	10,841,190			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,928	71,191	2,657,126	-5,864,361	19,444,966	5.00
6.00	00600	MAINTENANCE & REPAIRS	270	10,154	232,887	0	526,108	6.00
7.00	00700	OPERATION OF PLANT	14,369	51,855	0	0	1,115,560	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	316	0	0	0	69,728	8.00
9.00	00900	HOUSEKEEPING	1,189	636	270,547	0	470,839	9.00
10.00	01000	DIETARY	2,504	30,916	44,075	0	230,077	10.00
11.00	01100	CAFETERIA	1,176	0	276,073	0	388,288	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,264	1,848	98,911	0	191,158	14.00
15.00	01500	PHARMACY	951	0	47,245	0	334,994	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,548	14,145	527,806	0	836,491	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,596	56,270	1,332,354	0	2,326,942	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,514	74,693	366,171	0	1,253,752	50.00
53.00	05300	ANESTHESIOLOGY	0	0	129,732	0	83,024	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,658	304,721	699,973	0	1,818,858	54.00
56.00	03630	ULTRA SOUND	126	47,988	0	0	107,371	56.00
60.00	06000	LABORATORY	1,385	44,585	535,229	0	1,777,681	60.00
66.00	06600	PHYSICAL THERAPY	4,315	14,197	499,327	0	798,660	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	166,164	0	207,297	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	29,348	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	26,754	0	16,263	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	63,265	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	66,246	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	321,072	73.00
76.00	03950	SLEEP LAB	1,550	9,084	76,935	0	193,505	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	619	2,661	258,743	0	438,583	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,669	14,123	1,409,343	0	2,665,746	88.01
91.00	09100	EMERGENCY	6,295	19,432	859,598	0	2,512,115	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	866	59,031	252,059	0	454,934	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	71,108	827,530	10,767,052	-5,864,361	19,297,905	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	315	0	0	0	15,237	190.00
190.01	19001	FOUNDATION	100	0	66,752	0	105,502	190.01
190.02	19002	CROSSFIT	0	0	7,386	0	14,576	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	11,746	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,459,695	848,030	14,645		5,864,361	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	48.371783	1.024773	0.001351		0.301588	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		331,243	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.017035	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/29/2016 10:55 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	66,325					6.00
7.00	00700	OPERATION OF PLANT	14,369	51,337				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	316	316	81,871			8.00
9.00	00900	HOUSEKEEPING	1,189	1,189	612	50,451		9.00
10.00	01000	DIETARY	2,504	2,504	2,210	2,504	8,214	10.00
11.00	01100	CAFETERIA	1,176	1,176	0	1,176	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,264	1,264	0	1,264	0	14.00
15.00	01500	PHARMACY	951	951	0	951	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,548	1,548	0	1,548	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,596	9,596	33,422	9,596	8,214	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,514	6,514	8,252	6,514	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,658	3,658	8,374	3,658	0	54.00
56.00	03630	ULTRA SOUND	126	126	0	126	0	56.00
60.00	06000	LABORATORY	1,385	1,385	0	1,385	0	60.00
66.00	06600	PHYSICAL THERAPY	4,315	4,315	3,942	4,315	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SLEEP LAB	1,550	1,550	2,657	1,550	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	619	0	0	619	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,669	7,669	1,456	7,669	0	88.01
91.00	09100	EMERGENCY	6,295	6,295	20,136	6,295	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	866	866	810	866	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	65,910	50,922	81,871	50,036	8,214	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	315	315	0	315	0	190.00
190.01	19001	FOUNDATION	100	100	0	100	0	190.01
190.02	19002	CROSSFIT	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	684,776	1,600,354	103,871	662,955	439,084	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.324553	31.173501	1.268715	13.140572	53.455564	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	32,428	785,969	21,466	85,132	201,088	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.488926	15.309991	0.262193	1.687419	24.481130	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/29/2016 10:55 am

		Cost Center Description	CAFETERIA (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			11.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	13,117					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	291	1,411,139				14.00
15.00	01500	PHARMACY	106	2,116	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,329	6,444	0	10,000		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,340	41,727	0	1,280		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	684	152,808	0	578		50.00
53.00	05300	ANESTHESIOLOGY	39	462	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,269	31,181	0	474		54.00
56.00	03630	ULTRA SOUND	0	9,100	0	108		56.00
60.00	06000	LABORATORY	1,206	425,793	0	1,705		60.00
66.00	06600	PHYSICAL THERAPY	700	7,817	0	504		66.00
67.00	06700	OCCUPATIONAL THERAPY	208	13	0	8		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3		68.00
69.00	06900	ELECTROCARDIOLOGY	0	250	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	63,265	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	66,246	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	321,072	100	0		73.00
76.00	03950	SLEEP LAB	164	5,914	0	78		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	38,530	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	2,525	200,495	0	39		88.01
91.00	09100	EMERGENCY	1,051	30,799	0	4,697		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,061	6,347	0	526		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,973	1,410,379	100	10,000		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
190.01	19001	FOUNDATION	55	9	0	0		190.01
190.02	19002	CROSSFIT	89	751	0	0		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	569,646	330,510	493,085	1,232,573		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	43.428070	0.234215	4,930.850000	123.257300		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	84,063	90,629	108,134	143,070		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.408706	0.064224	1,081.340000	14.307000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/29/2016 10:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,303,682		4,303,682	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,134,992		2,134,992	0	0	50.00
53.00	05300	ANESTHESIOLOGY	109,865		109,865	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,698,733		2,698,733	0	0	54.00
56.00	03630	ULTRA SOUND	162,081		162,081	0	0	56.00
60.00	06000	LABORATORY	2,751,737		2,751,737	0	0	60.00
66.00	06600	PHYSICAL THERAPY	1,374,646	0	1,374,646	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	279,837	0	279,837	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	38,569	0	38,569	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	21,227		21,227	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	97,163		97,163	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	101,741		101,741	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	986,188		986,188	0	0	73.00
76.00	03950	SLEEP LAB	358,046		358,046	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	594,403		594,403	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,051,988		4,051,988	0	0	88.01
91.00	09100	EMERGENCY	4,271,032		4,271,032	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	241,673		241,673		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	752,879		752,879	0	0	95.00
200.00		Subtotal (see instructions)	25,330,482	0	25,330,482	0	0	200.00
201.00		Less Observation Beds	241,673		241,673		0	201.00
202.00		Total (see instructions)	25,088,809	0	25,088,809	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/29/2016 10:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,209,321		7,209,321			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,093	5,735,547	5,775,640	0.369655	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	463	537,859	538,322	0.204088	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	169,572	9,434,435	9,604,007	0.281001	0.000000	54.00
56.00	03630	ULTRA SOUND	75,485	1,179,784	1,255,269	0.129121	0.000000	56.00
60.00	06000	LABORATORY	608,627	12,947,354	13,555,981	0.202991	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	374,088	3,134,643	3,508,731	0.391779	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	237,302	104,746	342,048	0.818122	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	37,715	87,486	125,201	0.308057	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	11,226	477,759	488,985	0.043410	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	169,343	412,263	581,606	0.167060	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24	59,947	59,971	1.696503	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,129,426	2,758,929	3,888,355	0.253626	0.000000	73.00
76.00	03950	SLEEP LAB	0	1,374,093	1,374,093	0.260569	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	575,223	575,223			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,038,036	3,038,036			88.01
91.00	09100	EMERGENCY	4,957	5,925,746	5,930,703	0.720156	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	204,061	204,061	1.184317	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,334,320	2,334,320	0.322526	0.000000	95.00
200.00		Subtotal (see instructions)	10,067,642	50,322,231	60,389,873			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,067,642	50,322,231	60,389,873			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/29/2016 10:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	03630	ULTRA SOUND	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	SLEEP LAB	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/29/2016 10:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	661,854	5,775,640	0.114594	377	43	50.00
53.00	05300	ANESTHESIOLOGY	1,694	538,322	0.003147	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	726,887	9,604,007	0.075686	66,368	5,023	54.00
56.00	03630	ULTRA SOUND	61,434	1,255,269	0.048941	31,791	1,556	56.00
60.00	06000	LABORATORY	243,386	13,555,981	0.017954	178,199	3,199	60.00
66.00	06600	PHYSICAL THERAPY	326,147	3,508,731	0.092953	27,123	2,521	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,979	342,048	0.014556	7,630	111	67.00
68.00	06800	SPEECH PATHOLOGY	543	125,201	0.004337	12,699	55	68.00
69.00	06900	ELECTROCARDIOLOGY	293	488,985	0.000599	4,552	3	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,141	581,606	0.008839	84,990	751	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,384	59,971	0.089777	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	134,224	3,888,355	0.034519	304,917	10,525	73.00
76.00	03950	SLEEP LAB	118,828	1,374,093	0.086477	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	46,376	575,223	0.080623	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	597,586	3,038,036	0.196701	0	0	88.01
91.00	09100	EMERGENCY	565,277	5,930,703	0.095314	1,714	163	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	56,209	204,061	0.275452	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	3,556,242	50,846,232		720,360	23,950	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/29/2016 10:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	03630	ULTRA SOUND	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/29/2016 10:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,775,640	0.000000	0.000000	377	50.00
53.00	05300	ANESTHESIOLOGY	0	538,322	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,604,007	0.000000	0.000000	66,368	54.00
56.00	03630	ULTRA SOUND	0	1,255,269	0.000000	0.000000	31,791	56.00
60.00	06000	LABORATORY	0	13,555,981	0.000000	0.000000	178,199	60.00
66.00	06600	PHYSICAL THERAPY	0	3,508,731	0.000000	0.000000	27,123	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	342,048	0.000000	0.000000	7,630	67.00
68.00	06800	SPEECH PATHOLOGY	0	125,201	0.000000	0.000000	12,699	68.00
69.00	06900	ELECTROCARDIOLOGY	0	488,985	0.000000	0.000000	4,552	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	581,606	0.000000	0.000000	84,990	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	59,971	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,888,355	0.000000	0.000000	304,917	73.00
76.00	03950	SLEEP LAB	0	1,374,093	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	575,223	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,038,036	0.000000	0.000000	0	88.01
91.00	09100	EMERGENCY	0	5,930,703	0.000000	0.000000	1,714	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	204,061	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	50,846,232			720,360	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/29/2016 10:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	03630	ULTRA SOUND	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	SLEEP LAB	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/29/2016 10:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.369655	0	896,765	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.204088	0	132,058	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.281001	0	2,092,627	0	0	54.00
56.00	03630	ULTRA SOUND	0.129121	0	255,987	0	0	56.00
60.00	06000	LABORATORY	0.202991	0	3,163,377	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.391779	0	885,515	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.818122	0	22,506	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.308057	0	37,817	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.043410	0	155,981	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.167060	0	98,790	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.696503	0	6,795	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.253626	0	1,495,945	46,390	0	73.00
76.00	03950	SLEEP LAB	0.260569	0	183,796	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
91.00	09100	EMERGENCY	0.720156	0	1,507,136	20,979	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.184317	0	95,581	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.322526		2,644			95.00
200.00		Subtotal (see instructions)		0	11,033,320	67,369	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	11,033,320	67,369	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/29/2016 10:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	331,494	0	50.00
53.00	05300	ANESTHESIOLOGY	26,951	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	588,030	0	54.00
56.00	03630	ULTRA SOUND	33,053	0	56.00
60.00	06000	LABORATORY	642,137	0	60.00
66.00	06600	PHYSICAL THERAPY	346,926	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,413	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,650	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,771	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,504	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,528	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	379,411	11,766	73.00
76.00	03950	SLEEP LAB	47,892	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
91.00	09100	EMERGENCY	1,085,373	15,108	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	113,198	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	853		95.00
200.00		Subtotal (see instructions)	3,660,184	26,874	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	3,660,184	26,874	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141301 | Component CCN: 14Z301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/29/2016 10:55 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.369655	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.204088	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.281001	0	0	0	0	54.00
56.00	03630	ULTRA SOUND	0.129121	0	0	0	0	56.00
60.00	06000	LABORATORY	0.202991	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.391779	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.818122	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.308057	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.043410	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.167060	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.696503	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.253626	0	0	0	0	73.00
76.00	03950	SLEEP LAB	0.260569	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
91.00	09100	EMERGENCY	0.720156	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.184317	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.322526		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141301 | Component CCN: 14Z301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/29/2016 10:55 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	03630	ULTRA SOUND	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	SLEEP LAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/29/2016 10:55 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,154	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	634	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	532	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	522	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	638	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	158	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	202	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	312	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	329	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	361	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	147.50	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.50	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,303,682	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	23,305	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	29,795	25.00
26.00	Total swing-bed cost (see instructions)	2,801,523	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,502,159	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,502,159	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,369.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	739,231	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	739,231	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/29/2016 10:55 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	172,811	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	912,042	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	779,510	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	855,328	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,634,838	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	102	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,369.34	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	241,673	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/29/2016 10:55 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,000,956	4,303,682	0.232581	241,673	56,209	90.00
91.00	Nursing School cost	0	4,303,682	0.000000	241,673	0	91.00
92.00	Allied health cost	0	4,303,682	0.000000	241,673	0	92.00
93.00	All other Medical Education	0	4,303,682	0.000000	241,673	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/29/2016 10:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,300,906		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.369655	377	139	50.00
53.00	05300	ANESTHESIOLOGY	0.204088	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.281001	66,368	18,649	54.00
56.00	03630	ULTRA SOUND	0.129121	31,791	4,105	56.00
60.00	06000	LABORATORY	0.202991	178,199	36,173	60.00
66.00	06600	PHYSICAL THERAPY	0.391779	27,123	10,626	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.818122	7,630	6,242	67.00
68.00	06800	SPEECH PATHOLOGY	0.308057	12,699	3,912	68.00
69.00	06900	ELECTROCARDIOLOGY	0.043410	4,552	198	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.167060	84,990	14,198	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.696503	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.253626	304,917	77,335	73.00
76.00	03950	SLEEP LAB	0.260569	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	0.720156	1,714	1,234	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.184317	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		720,360	172,811	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)		720,360		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141301 | Component CCN: 14Z301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/29/2016 10:55 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.369655	39,716	14,681	50.00
53.00	05300	ANESTHESIOLOGY	0.204088	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.281001	33,596	9,441	54.00
56.00	03630	ULTRA SOUND	0.129121	11,062	1,428	56.00
60.00	06000	LABORATORY	0.202991	170,382	34,586	60.00
66.00	06600	PHYSICAL THERAPY	0.391779	188,050	73,674	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.818122	115,402	94,413	67.00
68.00	06800	SPEECH PATHOLOGY	0.308057	13,960	4,300	68.00
69.00	06900	ELECTROCARDIOLOGY	0.043410	3,545	154	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.167060	36,130	6,036	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.696503	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.253626	360,520	91,437	73.00
76.00	03950	SLEEP LAB	0.260569	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	0.720156	2,888	2,080	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.184317	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		975,251	332,230	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)		975,251		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141301	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/29/2016 10:55 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,687,058	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,687,058	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	3,723,929	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	19,118	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,580,651	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,124,160	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,124,160	30.00
31.00	Primary payer payments	3,809	31.00
32.00	Subtotal (line 30 minus line 31)	2,120,351	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	220,116	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	143,075	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	2,263,426	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,263,426	40.00
40.01	Sequestration adjustment (see instructions)	45,269	40.01
41.00	Interim payments	2,302,919	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-84,762	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/29/2016 10:55 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		763,896		2,302,919	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	12/28/2015	90,800		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-90,800		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		673,096		2,302,919	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		147,379		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		84,762	6.02
7.00	Total Medicare program liability (see instructions)		820,475		2,218,157	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/29/2016 10:55 am

Component CCN: 14Z301 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,827,774		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	12/28/2015	201,900		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-201,900		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,625,874		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		314,752		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,940,626		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141301	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/29/2016 10:55 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	170	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	312	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	123	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	532	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	60,389,873	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	3,954,555	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	667,972	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	667,972	8.00
9.00	Sequestration adjustment amount (see instructions)	13,359	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	654,613	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	654,613	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141301 Component CCN: 14Z301	Period: From 07/01/2015 To 06/30/2016	Worksheet E-2 Date/Time Prepared: 11/29/2016 10:55 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,651,186	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	335,552	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	690	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,986,738	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,986,738	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,986,738	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,507	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,980,231	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,980,231	0	19.00
19.01	Sequestration adjustment (see instructions)	39,605	0	19.01
20.00	Interim payments	1,625,874	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	314,752	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141301	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part V Date/Time Prepared: 11/29/2016 10:55 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	912,042	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	912,042	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	921,162	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	921,162	19.00
20.00	Deductibles (exclude professional component)	89,096	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	832,066	22.00
23.00	Coinsurance	315	23.00
24.00	Subtotal (line 22 minus line 23)	831,751	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	8,412	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	5,468	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	837,219	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	837,219	30.00
30.01	Sequestration adjustment (see instructions)	16,744	30.01
31.00	Interim payments	673,096	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	147,379	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G | Date/Time Prepared: 11/29/2016 10:55 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,245,155	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,585,266	0	0	0	4.00
5.00	Other receivable	135,899	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	235,863	0	0	0	7.00
8.00	Prepaid expenses	1,128,201	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,330,384	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	349,650	0	0	0	12.00
13.00	Land improvements	5,740,119	0	0	0	13.00
14.00	Accumulated depreciation	-1,348,310	0	0	0	14.00
15.00	Buildings	16,726,258	0	0	0	15.00
16.00	Accumulated depreciation	-4,393,359	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	10,748,624	0	0	0	19.00
20.00	Accumulated depreciation	-3,116,961	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	6,646,009	0	0	0	23.00
24.00	Accumulated depreciation	-3,716,706	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	3,070,784	0	0	0	27.00
28.00	Accumulated depreciation	-2,711,276	0	0	0	28.00
29.00	Minor equipment-nondepreciable	141,561	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	28,136,393	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	39,149,167	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	387,217	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	39,536,384	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	78,003,161	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,334,819	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,049,771	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	745,962	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	239,064	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,369,616	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	26,788,079	0	0	0	46.00
47.00	Notes payable	63,988	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	20,001	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	26,872,068	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	31,241,684	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	46,761,477				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	46,761,477	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	78,003,161	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-1 | Date/Time Prepared: 11/29/2016 10:55 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		43,363,278		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,398,200				2.00
3.00	Total (sum of line 1 and line 2)		46,761,478		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		46,761,478		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		46,761,478		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/29/2016 10:55 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,209,321		7,209,321	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,209,321		7,209,321	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,209,321		7,209,321	17.00
18.00	Ancillary services	2,852,901	36,502,429	39,355,330	18.00
19.00	Outpatient services	4,957	6,129,807	6,134,764	19.00
20.00	RURAL HEALTH CLINIC	0	575,223	575,223	20.00
20.01	RURAL HEALTH CLINIC II	0	3,038,036	3,038,036	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	2,334,320	2,334,320	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	172,916	5,849,274	6,022,190	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,240,095	54,429,089	64,669,184	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,127,807		29.00
30.00	JEFFERSON PARKWAY OTHER EXPENSE	16,851			30.00
31.00	GAIN/LOSS ON SALE OF ASSETS	45,575			31.00
32.00	UNREALIZED GAIN/LOSS ON INVESTMENTS	376			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)		62,802		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		28,190,609		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141301	Period: From 07/01/2015 To 06/30/2016	Worksheet G-3 Date/Time Prepared: 11/29/2016 10:55 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	64,669,184	1.00
2.00	Less contractual allowances and discounts on patients' accounts	34,775,651	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,893,533	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,190,609	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,702,924	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	362,407	6.00
7.00	Income from investments	-290,889	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	92,924	23.00
24.00	TRUST HOSPITAL INCOME	886,634	24.00
24.01	EHR INCENTIVE REIMBURSEMENT	71,615	24.01
24.02	OTHER DOCTOR BUILDING INCOME	35,898	24.02
24.03	JEFFERSON PARKWAY	8,955	24.03
24.04	340B NET REVENUES	184,851	24.04
24.05	PHYSICAL THERAPY	98,138	24.05
24.06	CAFETERIA MEALS	161,821	24.06
24.07	MISCELLANEOUS INCOME	20,120	24.07
25.00	Total other income (sum of lines 6-24)	1,632,474	25.00
26.00	Total (line 5 plus line 25)	3,335,398	26.00
27.00	JEFFERSON PARKWAY OTHER EXPENSE	-16,851	27.00
27.01	GAIN/LOSS ON SALE OF ASSETS	-45,575	27.01
27.02	UNREALIZED GAIN/LOSS ON INVESTMENTS	-376	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	-62,802	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,398,200	29.00

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

Provider CCN: 141301 Component CCN: 143438 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-1 | Date/Time Prepared: 11/29/2016 10:55 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	3,767	0	3,767	0	3,767	2.00
3.00	Nurse Practitioner	120,424	0	120,424	0	120,424	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	134,553	0	134,553	0	134,553	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	6,900	6,900	0	6,900	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	258,744	6,900	265,644	0	265,644	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	57,308	57,308	0	57,308	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	1,550	1,550	0	1,550	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	58,858	58,858	0	58,858	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	258,744	65,758	324,502	0	324,502	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	18,106	18,106	0	18,106	29.00
30.00	Administrative Costs	46,922	72,314	119,236	-56,280	62,956	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	46,922	90,420	137,342	-56,280	81,062	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	305,666	156,178	461,844	-56,280	405,564	32.00

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

Provider CCN: 141301 | Component CCN: 143438 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-1 | Date/Time Prepared: 11/29/2016 10:55 am

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	3,767		2.00
3.00	Nurse Practitioner	0	120,424		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	134,553		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	6,900		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	265,644		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	57,308		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	1,550		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	58,858		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	324,502		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	18,106		29.00
30.00	Administrative Costs	0	62,956		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	81,062		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	405,564		32.00

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

Provider CCN: 141301 Component CCN: 143495 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-1 | Date/Time Prepared: 11/29/2016 10:55 am

Rural Health Clinic (RHC) II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	454,916	0	454,916	0	454,916	1.00
2.00	Physician Assistant	221,182	0	221,182	0	221,182	2.00
3.00	Nurse Practitioner	101,887	0	101,887	0	101,887	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	427,462	0	427,462	0	427,462	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	85,100	85,100	0	85,100	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,205,447	85,100	1,290,547	0	1,290,547	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	285,836	285,836	0	285,836	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	285,836	285,836	0	285,836	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,205,447	370,936	1,576,383	0	1,576,383	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	16,277	16,277	0	16,277	29.00
30.00	Administrative Costs	365,679	515,305	880,984	-195,238	685,746	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	365,679	531,582	897,261	-195,238	702,023	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,571,126	902,518	2,473,644	-195,238	2,278,406	32.00

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

Provider CCN: 141301 | Component CCN: 143495 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-1 | Date/Time Prepared: 11/29/2016 10:55 am

Rural Health Clinic (RHC) II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	454,916		1.00
2.00	Physician Assistant	0	221,182		2.00
3.00	Nurse Practitioner	0	101,887		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	427,462		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	85,100		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,290,547		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	285,836		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	285,836		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,576,383		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	16,277		29.00
30.00	Administrative Costs	0	685,746		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	702,023		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,278,406		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-2

Component CCN: 143438 | Date/Time Prepared: 11/29/2016 10:55 am

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	1	4,200	0		1.00
2.00	Physician Assistant	0.04	141	2,100	84		2.00
3.00	Nurse Practitioner	1.05	3,273	2,100	2,205		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.09	3,415		2,289	3,415	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	71			71	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.09	3,486			3,486	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					324,502	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					324,502	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					81,062	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					188,839	15.00
16.00	Total overhead (sum of lines 14 and 15)					269,901	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					269,901	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					269,901	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					594,403	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-2

Component CCN: 143495 | Date/Time Prepared: 11/29/2016 10:55 am

Rural Health Clinic (RHC) II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.95	7,102	4,200	8,190		1.00
2.00	Physician Assistant	2.00	6,697	2,100	4,200		2.00
3.00	Nurse Practitioner	1.31	2,028	2,100	2,751		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.26	15,827		15,141	15,827	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	824			824	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.26	16,651			16,651	8.00
9.00	Physician Services Under Agreements		610			610	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,576,383	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,576,383	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					702,023	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,773,582	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,475,605	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					2,475,605	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					2,475,605	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					4,051,988	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141301 Component CCN: 143438	Period: From 07/01/2015 To 06/30/2016	Worksheet M-3 Date/Time Prepared: 11/29/2016 10:55 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		594,403	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		14,847	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		579,556	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,486	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		3,486	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		166.25	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions)	166.25	166.25	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	395	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	65,669	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		65,669	16.00
16.01	Total program charges (see instructions)(from contractor's records)		65,575	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		201	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		201	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		45,845	16.04
16.05	Total program cost (see instructions)		46,046	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,162	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		11,442	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		46,046	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,939	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		50,985	22.00
23.00	Allowable bad debts (see instructions)		1,998	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		1,299	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		52,284	26.00
26.01	Sequestration adjustment (see instructions)		1,046	26.01
27.00	Interim payments		36,982	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		14,256	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141301 Component CCN: 143495	Period: From 07/01/2015 To 06/30/2016	Worksheet M-3 Date/Time Prepared: 11/29/2016 10:55 am
	Title XVIII	Rural Health Clinic (RHC) II	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		4,051,988	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		123,371	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		3,928,617	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		16,651	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		610	5.00
6.00	Total adjusted visits (line 4 plus line 5)		17,261	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		227.60	7.00

		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions)	227.60	227.60	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	3,061	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	696,684	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		696,684	16.00
16.01	Total program charges (see instructions)(from contractor's records)		536,746	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		16,024	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		20,799	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		496,863	16.04
16.05	Total program cost (see instructions)		517,662	16.05
17.00	Primary payer amounts		152	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		54,806	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		93,183	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		517,510	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		57,536	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		575,046	22.00
23.00	Allowable bad debts (see instructions)		22,627	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		14,708	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		589,754	26.00
26.01	Sequestration adjustment (see instructions)		11,795	26.01
27.00	Interim payments		585,532	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		-7,573	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 141301 Component CCN: 143438	Period: From 07/01/2015 To 06/30/2016	Worksheet M-4 Date/Time Prepared: 11/29/2016 10:55 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	265,644	265,644	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.004687	0.007616	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,245	2,023	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	4,826	11	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	6,071	2,034	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	324,502	324,502	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	269,901	269,901	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.018709	0.006268	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	5,050	1,692	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	11,121	3,726	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	64	104	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	173.77	35.83	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	21	36	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,649	1,290	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		14,847	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		4,939	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141301 | Component CCN: 143495 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-4 | Date/Time Prepared: 11/29/2016 10:55 am

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,290,547	1,290,547	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.005393	0.006733	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	6,960	8,689	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	26,695	5,652	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	33,655	14,341	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,576,383	1,576,383	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	2,475,605	2,475,605	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.021350	0.009097	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	52,854	22,521	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	86,509	36,862	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	354	442	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	244.38	83.40	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	188	139	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	45,943	11,593	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		123,371	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		57,536	16.00

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

Provider CCN: 141301 Component CCN: 143438 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-5 | Date/Time Prepared: 11/29/2016 10:55 am

Rural Health Clinic (RHC) I | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		36,982	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		36,982	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		14,256	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		51,238	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141301 Component CCN: 143495	Period: From 07/01/2015 To 06/30/2016	Worksheet M-5 Date/Time Prepared: 11/29/2016 10:55 am
		Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		585,532	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		585,532	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		7,573	6.02
7.00	Total Medicare program liability (see instructions)		577,959	7.00

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