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: 141304	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/18/2016 12:58 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/18/2016 Time: 12:58 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GENESIS MEDICAL CENTER - ALEDO (141304) 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)

VICE PRESIDENT FINANCE/CFO
Title

11/28/2016
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	-14,059	-73,908	63,415	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	-50,694	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-17,513		0	10.00
200.00	Total	0	-64,753	-91,421	63,415	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: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/18/2016 12:44 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 409 N.W. NINTH AVENUE	PO Box:			1.00
2.00	City: ALEDO	State: IL	Zip Code: 61231-	County: MERCER	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	GENESIS MEDICAL CENTER - ALEDO	141304	99914	1	05/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GENESIS MEDICAL CENTER - ALEDO, SWB	14Z304	99914		05/01/2000	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	GENESIS MEDICAL CENTER - ALEDO, RHC	143453	99914		02/29/2000	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 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.	0		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2016 12:44 pm

		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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/18/2016 12:44 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2016 12:44 pm

		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

		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

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		V	XIX	
		1.00	2.00	
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.	Y	N	N	N	109.00

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, 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.	N			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:	14,742	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2016 12:44 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	H55790	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: GENESIS HEALTH SYSTEM	Contractor's Name: WISCONSIN PHYSICIAN SERVICE HEALTH	Contractor's Number: 05001	141.00
142.00	Street: 1227 E RUSHOLME STREET	PO Box:		142.00
143.00	City: DAVENPORT	State: IA	Zip Code: 52803	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

		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)	64,709	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.75	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141304	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/18/2016 12:44 pm

		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: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 11/18/2016 12:44 pm

		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)	Y			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	10/14/2016	Y	10/14/2016	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: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 11/18/2016 12:44 pm

		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.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MARTY	ORWITZ	41.00
42.00	Enter the employer/company name of the cost report preparer.	GENESIS HEALTH SYSTEM		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-421-4175	ORWITZM@GENESISHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 141304	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/18/2016 12:44 pm

		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: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/18/2016 12:44 pm

	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	22	8,052	11,544.00	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)		22	8,052	11,544.00	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)		22	8,052	11,544.00	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
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		22				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: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/18/2016 12:44 pm

	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)	306	12	481			1.00
2.00	HMO and other (see instructions)	96	20				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	656	0	861			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	21			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	962	12	1,363			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)	962	12	1,363	0.00	74.06	14.00
15.00	CAH visits	5,933	815	17,859			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	3,184	5,576	17,716	0.00	14.66	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	88.72	27.00
28.00	Observation Bed Days		7	225			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: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/18/2016 12:44 pm

	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	89	6	237	1.00
2.00	HMO and other (see instructions)			47	10		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	89	6	237	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
26.25	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: 141304 Component CCN: 143453 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-8 Date/Time Prepared: 11/18/2016 12:44 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1007 NW 3RD STREET	1.00
		City: 1.00	State: 2.00	ZIP Code: 3.00
2.00	City, State, ZIP Code, County	ALEDO	IL	61231	2.00
				1.00
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
			Grant Award: 1.00	Date: 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: 1.00	to: 2.00	from: 3.00	to: 4.00	from: 5.00	
	Facility hours of operations (1)						
11.00	Clinic			07:00	19:00	08:00	11.00

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

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

		Y/N: 1.00	V: 2.00	XVIII: 3.00	XIX: 4.00	Total Visits: 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		MERCER			2.00

		Tuesday	Wednesday		Thursday		
		to: 6.00	from: 7.00	to: 8.00	from: 9.00	to: 10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141304 Component CCN: 143453	Period: From 07/01/2015 To 06/30/2016	Worksheet S-8 Date/Time Prepared: 11/18/2016 12:44 pm
		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	07:00	18:00	08:00	12:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-10 | Date/Time Prepared: 11/18/2016 12:44 pm

		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)	0.516082	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,355,114	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	4,154,090	6.00
7.00	Medicaid cost (line 1 times line 6)	2,143,851	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)	788,737	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)	788,737	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	313,348	0	313,348	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	161,713	0	161,713	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	161,713	0	161,713	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)	677,589	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	84,359	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	593,230	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	306,155	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	467,868	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,256,605	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/18/2016 12:44 pm

		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		731,810	731,810	0	731,810	1.00
1.01	00101	FOUNDATION BLDG		0	0	0	0	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		234,409	234,409	0	234,409	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	23,660	662,700	686,360	0	686,360	4.00
5.01	00570	ADMITTING	93,506	9,067	102,573	0	102,573	5.01
5.02	00590	HOSPITAL ONLY A & G	0	184,140	184,140	0	184,140	5.02
5.03	00591	SHARED ADMN & GENERAL	293,801	2,278,861	2,572,662	188,301	2,760,963	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	529,432	529,432	0	529,432	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,863	2,107	28,970	-68	28,902	8.00
9.00	00900	HOUSEKEEPING	0	196,882	196,882	0	196,882	9.00
10.00	01000	DIETARY	0	107,422	107,422	0	107,422	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	136,168	136,168	0	136,168	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	59,056	5,342	64,398	0	64,398	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	224,510	224,510	-8,085	216,425	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	701,701	217,077	918,778	-19,123	899,655	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	152,453	226,218	378,671	-123,240	255,431	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	414,412	300,402	714,814	-574	714,240	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	395,610	590,720	986,330	-16,578	969,752	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	16,578	16,578	63.00
65.00	06500	RESPIRATORY THERAPY	172,967	44,627	217,594	-958	216,636	65.00
66.00	06600	PHYSICAL THERAPY	286,131	105,471	391,602	0	391,602	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	37,781	37,781	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	113,627	113,627	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	233,599	408,177	641,776	-64,824	576,952	73.00
76.00	03950	SLEEP LAB	25,290	7,550	32,840	-641	32,199	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,392,241	418,206	1,810,447	-175,314	1,635,133	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	707,115	1,176,909	1,884,024	-5,809	1,878,215	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		418,449	418,449	0	418,449	113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,978,405	9,216,656	14,195,061	-58,927	14,136,134	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	424,749	171,429	596,178	-5,883	590,295	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	NONPATIENT RELATED MEALS	0	0	0	0	0	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07955	RETAIL PHARMACY	0	3,304	3,304	64,810	68,114	194.04
200.00		TOTAL (SUM OF LINES 118-199)	5,403,154	9,391,389	14,794,543	0	14,794,543	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/18/2016 12:44 pm

		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	0	731,810		1.00
1.01	00101	FOUNDATION BLDG	0	0		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-96,412	137,997		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-123,805	562,555		4.00
5.01	00570	ADMITTING	0	102,573		5.01
5.02	00590	HOSPITAL ONLY A & G	-30,655	153,485		5.02
5.03	00591	SHARED ADMN & GENERAL	-481,600	2,279,363		5.03
6.00	00600	MAINTENANCE & REPAIRS	0	529,432		6.00
7.00	00700	OPERATION OF PLANT	0	0		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	28,902		8.00
9.00	00900	HOUSEKEEPING	0	196,882		9.00
10.00	01000	DIETARY	-678	106,744		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	93,715	93,715		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,316	155,484		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	158,887	158,887		16.00
17.00	01700	SOCIAL SERVICE	0	64,398		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	216,425		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	899,655		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	255,431		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	714,240		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	-28	969,724		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	16,578		63.00
65.00	06500	RESPIRATORY THERAPY	-13,998	202,638		65.00
66.00	06600	PHYSICAL THERAPY	-5,354	386,248		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	37,781		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	113,627		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-5,937	571,015		73.00
76.00	03950	SLEEP LAB	0	32,199		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-99,688	1,535,445		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-136,961	1,741,254		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04040	INFUSION CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-418,449	0		113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,141,647	12,994,487		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-252,323	337,972		192.00
194.00	07950	BOARD OF HEALTH	0	0		194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0		194.01
194.02	07952	NONPATIENT RELATED MEALS	0	0		194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.03
194.04	07955	RETAIL PHARMACY	0	68,114		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-1,393,970	13,400,573		200.00

RECLASSIFICATIONS | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/18/2016 12:44 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RHC SALARY				
1.00	SHARED ADMN & GENERAL	5.03	174,790	0	1.00
	TOTALS		174,790	0	
	B - BLOOD				
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	4,344	12,234	1.00
	TOTALS		4,344	12,234	
	C - MALPRACTICE INSURANCE				
1.00	SHARED ADMN & GENERAL	5.03	0	13,511	1.00
	TOTALS		0	13,511	
	D - MEDICAL SUPPLIES CHARGED TO PATIENTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	151,408	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
	TOTALS		0	151,408	
	E - COST OF IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	113,627	1.00
	TOTALS		0	113,627	
	F - RETAIL PHARMACY				
1.00	RETAIL PHARMACY	194.04	0	64,810	1.00
	TOTALS		0	64,810	
	G - CRNA CLINIC SERVICES				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	8,085	1.00
	TOTALS		0	8,085	
500.00	Grand Total: Increases		179,134	363,675	500.00

RECLASSIFICATIONS | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/18/2016 12:44 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - RHC SALARY					
1.00	RURAL HEALTH CLINIC	88.00	174,790	0	0	1.00
	TOTALS		174,790	0		
	B - BLOOD					
1.00	LABORATORY	60.00	4,344	12,234	0	1.00
	TOTALS		4,344	12,234		
	C - MALPRACTICE INSURANCE					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	13,511	0	1.00
	TOTALS		0	13,511		
	D - MEDICAL SUPPLIES CHARGED TO PATIENTS					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	68	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	19,123	0	2.00
3.00	OPERATING ROOM	50.00	0	123,240	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	574	0	4.00
5.00	RESPIRATORY THERAPY	65.00	0	958	0	5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	14	0	6.00
7.00	SLEEP LAB	76.00	0	641	0	7.00
8.00	RURAL HEALTH CLINIC	88.00	0	524	0	8.00
9.00	EMERGENCY	91.00	0	5,809	0	9.00
10.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	457	0	10.00
	TOTALS		0	151,408		
	E - COST OF IMPLANTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	113,627	0	1.00
	TOTALS		0	113,627		
	F - RETAIL PHARMACY					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	64,810	0	1.00
	TOTALS		0	64,810		
	G - CRNA CLINIC SERVICES					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	8,085	9	1.00
	TOTALS		0	8,085		
500.00	Grand Total: Decreases		179,134	363,675		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 11/18/2016 12:44 pm

		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	65,000	0	0	0	0	1.00
2.00	Land Improvements	32,229	116,132	0	116,132	0	2.00
3.00	Buildings and Fixtures	11,779,241	282,398	0	282,398	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,901,186	0	0	0	41,809	5.00
6.00	Movable Equipment	109,793	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	13,887,449	398,530	0	398,530	41,809	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	13,887,449	398,530	0	398,530	41,809	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	65,000	0	1.00
2.00	Land Improvements	148,361	0	2.00
3.00	Buildings and Fixtures	12,061,639	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	1,859,377	0	5.00
6.00	Movable Equipment	109,793	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,244,170	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	14,244,170	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 11/18/2016 12:44 pm

	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	731,810	0	0	0	0	1.00
1.01	FOUNDATION BLDG	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	234,409	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	966,219	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	731,810		1.00
1.01	FOUNDATION BLDG	0	0		1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	234,409		2.00
3.00	Total (sum of lines 1-2)	0	966,219		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 11/18/2016 12:44 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	12,061,638	0	12,061,638	0.990979	0	1.00
1.01	FOUNDATION BLDG	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	109,793	0	109,793	0.009021	0	2.00
3.00	Total (sum of lines 1-2)	12,171,431	0	12,171,431	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	731,810	0	1.00
1.01	FOUNDATION BLDG	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	137,997	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	869,807	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	731,810	1.00
1.01	FOUNDATION BLDG	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	137,997	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	869,807	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/18/2016 12:44 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - FOUNDATION BLDG (chapter 2)		0	FOUNDATION BLDG	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-3,219	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-187,582			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	-503,747			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - FOUNDATION BLDG		0	FOUNDATION BLDG	1.01	0	26.01
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	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/18/2016 12:44 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-93,130	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	-145	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
34.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	-3,936	SHARED ADMN & GENERAL	5.03	0	34.00
35.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	-678	DIETARY	10.00	0	35.00
37.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	-28	LABORATORY	60.00	0	37.00
38.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	-80	RESPIRATORY THERAPY	65.00	0	38.00
39.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	-88	PHYSICAL THERAPY	66.00	0	39.00
40.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	-5,937	DRUGS CHARGED TO PATIENTS	73.00	0	40.00
41.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	-60,724	RURAL HEALTH CLINIC	88.00	0	41.00
42.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	-72	EMERGENCY	91.00	0	42.00
43.00	PATIENT PHONES DEPRECIATION	A	-63	CAP REL COSTS-MVBLE EQUIP	2.00	9	43.00
44.00	PATIENT PHONES SALARY	A	-854	RURAL HEALTH CLINIC	88.00	0	44.00
45.00	PATIENT PHONES BENEFITS	A	-109	EMPLOYEE BENEFITS DEPARTMENT	4.00	9	45.00
45.01	PATIENT PHONES COST	A	-9	SHARED ADMN & GENERAL	5.03	0	45.01
45.02	ADVERTISING	A	-12,074	SHARED ADMN & GENERAL	5.03	0	45.02
45.03	ADVERTISING	A	-5,266	PHYSICAL THERAPY	66.00	0	45.03
45.04	ADVERTISING	A	-1,335	RURAL HEALTH CLINIC	88.00	0	45.04
45.05	ADVERTISING	A	-1,529	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.05
45.06	PROVIDER TAX ASSESSMENT	A	-131,263	SHARED ADMN & GENERAL	5.03	0	45.06
45.07	IHA LOBBYING FEES	A	-6,502	SHARED ADMN & GENERAL	5.03	0	45.07
45.08	AHA LOBBYING DUES	A	-1,255	SHARED ADMN & GENERAL	5.03	0	45.08
45.09	EMPLOYEE HEALTH INSURANCE	A	-123,551	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.09
45.10	PROFESSIONAL FEES OFFSET 100% PART B	A	-250,794	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,393,970				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/18/2016 12:44 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.03	SHARED ADMN & GENERAL	SHARED ADMIN & GENERAL	270,534	0	1.00
2.00	5.02	HOSPITAL ONLY A & G	A&G HOSPITAL ONLY	153,112	183,767	2.00
3.00	5.03	SHARED ADMN & GENERAL	SHARED ADMIN & GENERAL	167,313	626,134	3.00
4.00	5.03	SHARED ADMN & GENERAL	SHARED ADMIN & GENERAL	742,235	1,297,229	4.00
4.01	5.03	SHARED ADMN & GENERAL	SHARED ADMIN & GENERAL	1,156	0	4.01
4.02	5.03	SHARED ADMN & GENERAL	SHARED ADMIN & GENERAL	146,585	0	4.02
4.03	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS & LIBRARY	158,887	0	4.03
4.06	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SERVICES & SUPPLY	19,316	0	4.06
4.10	5.03	SHARED ADMN & GENERAL	SHARED ADMIN & GENERAL	24,537	0	4.10
4.11	5.03	SHARED ADMN & GENERAL	SHARED ADMIN & GENERAL	10,793	0	4.11
4.12	13.00	NURSING ADMINISTRATION	NURSING ADMINISTRATION	93,715	0	4.12
4.13	5.03	SHARED ADMN & GENERAL	SHARED ADMIN & GENERAL	9,671	0	4.13
4.14	5.03	SHARED ADMN & GENERAL	SHARED ADMIN & GENERAL	5,162	0	4.14
4.15	5.03	SHARED ADMN & GENERAL	SHARED ADMIN & GENERAL	218,816	0	4.15
4.16	5.03	SHARED ADMN & GENERAL	SHARED ADMIN & GENERAL	14	14	4.16
4.17	6.00	MAINTENANCE & REPAIRS	MAINTENANCE & REPAIRS	6,298	6,298	4.17
4.18	9.00	HOUSEKEEPING	HOUSEKEEPING	242	242	4.18
4.19	30.00	ADULTS & PEDIATRICS	ADULTS & PEDIATRICS	13,665	13,665	4.19
4.20	50.00	OPERATING ROOM	OPERATING ROOM	2,171	2,171	4.20
4.21	54.00	RADIOLOGY-DIAGNOSTIC	RADIOLOGY-DIAGNOSTIC	2,229	2,229	4.21
4.22	60.00	LABORATORY	LABORATORY	12,812	12,812	4.22
4.24	65.00	RESPIRATORY THERAPY	RESPIRATORY THERAPY	2,475	2,475	4.24
4.25	66.00	PHYSICAL THERAPY	PHYSICAL THERAPY	852	852	4.25
4.26	73.00	DRUGS CHARGED TO PATIENTS	DRUGS CHARGED TO PATIENTS	23,129	23,129	4.26
4.27	76.00	SLEEP LAB	SLEEP LAB	50	50	4.27
4.28	88.00	RURAL HEALTH CLINIC	RURAL HEALTH CLINIC	635	635	4.28
4.29	91.00	EMERGENCY	EMERGENCY	9,898	9,898	4.29
4.30	192.00	PHYSICIANS' PRIVATE OFFICES	PHYSICIANS' PRIVATE OFFICES	3,269	3,269	4.30
4.31	113.00	INTEREST EXPENSE	INTEREST EXPENSE	0	418,449	4.31
4.32	0.00			0	0	4.32
4.33	0.00			0	0	4.33
4.34	0.00			0	0	4.34
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,099,571	2,603,318	5.00

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

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

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

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

6.00	A	GMC ALEDO	100.00	GENESIS HLTH SY	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141304	Period: From 07/01/2015 To 06/30/2016	Worksheet A-8-1 Date/Time Prepared: 11/18/2016 12:44 pm

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141304	Period: From 07/01/2015 To 06/30/2016	Worksheet A-8-1 Date/Time Prepared: 11/18/2016 12:44 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	270,534	9		1.00
2.00	-30,655	0		2.00
3.00	-458,821	0		3.00
4.00	-554,994	0		4.00
4.01	1,156	0		4.01
4.02	146,585	0		4.02
4.03	158,887	0		4.03
4.06	19,316	0		4.06
4.10	24,537	0		4.10
4.11	10,793	0		4.11
4.12	93,715	0		4.12
4.13	9,671	0		4.13
4.14	5,162	0		4.14
4.15	218,816	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.24	0	0		4.24
4.25	0	0		4.25
4.26	0	0		4.26
4.27	0	0		4.27
4.28	0	0		4.28
4.29	0	0		4.29
4.30	0	0		4.30
4.31	-418,449	0		4.31
4.32	0	0		4.32
4.33	0	0		4.33
4.34	0	0		4.34
5.00	-503,747			5.00

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

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

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

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

6.00	NOT-FOR PROFIT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 11/18/2016 12:44 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	AGGREGATE-EMERGENCY	1,031,391	136,889	894,502	0	0	1.00
2.00	88.00	AGGREGATE-RURAL HEALTH CLINIC	880,279	36,775	843,504	0	0	2.00
3.00	65.00	AGGREGATE-RESPIRATORY THERAPY	13,918	13,918	0	0	0	3.00
4.00	0.00	AGGREGATE-	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,925,588	187,582	1,738,006		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	1.00
2.00	88.00	AGGREGATE-RURAL HEALTH CLINIC	0	0	0	0	0	2.00
3.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	0.00	AGGREGATE-	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	AGGREGATE-EMERGENCY	0	0	0	136,889		1.00
2.00	88.00	AGGREGATE-RURAL HEALTH CLINIC	0	0	0	36,775		2.00
3.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	13,918		3.00
4.00	0.00	AGGREGATE-	0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	187,582		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/18/2016 12:44 pm

Physical Therapy — Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	46	1.00
2.00	Line 1 multiplied by 15 hours per week	690	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	197	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	5.50	7.00
8.00	Optional travel expense rate per mile	0.55	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,199.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.10	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)	36.55	36.55	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)	87,683	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)	87,683	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)	87,683	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)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	87,683	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)	7,200	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)	7,200	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)	1,084	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	8,284	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)	8,284	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: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/18/2016 12:44 pm

Physical Therapy | 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)	73.10	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)	87,683		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	8,284		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)	95,967		63.00
64.00	Total cost of outside supplier services (from your records)	47,486		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	7,200		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,084		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	8,284		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	1,084		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	1,084		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: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/18/2016 12:44 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	FOUNDATION BLDG	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	731,810	731,810				1.00
1.01	00101	FOUNDATION BLDG	0	0	0			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	137,997			137,997		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	562,555	0	0	0	562,555	4.00
5.01	00570	ADMITTING	102,573	0	0	954	9,887	5.01
5.02	00590	HOSPITAL ONLY A & G	153,485	859	0	0	0	5.02
5.03	00591	SHARED ADMN & GENERAL	2,279,363	148,165	0	6,723	49,547	5.03
6.00	00600	MAINTENANCE & REPAIRS	529,432	67,244	0	12,520	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,902	1,994	0	0	2,840	8.00
9.00	00900	HOUSEKEEPING	196,882	9,633	0	0	0	9.00
10.00	01000	DIETARY	106,744	30,493	0	1,864	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	93,715	1,549	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	155,484	25,692	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	158,887	3,344	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	64,398	2,301	0	0	6,244	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	216,425	859	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	899,655	142,218	0	6,302	74,196	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	255,431	77,643	0	24,371	16,120	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	714,240	66,799	0	73,347	43,819	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	969,724	25,983	0	1,086	41,371	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	16,578	0	0	0	459	63.00
65.00	06500	RESPIRATORY THERAPY	202,638	4,878	0	0	18,289	65.00
66.00	06600	PHYSICAL THERAPY	386,248	36,429	0	4,563	30,255	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	37,781	0	0	2,556	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	113,627	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	571,015	9,080	0	0	24,700	73.00
76.00	03950	SLEEP LAB	32,199	12,961	0	90	2,674	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,535,445	0	0	156	122,474	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,741,254	36,383	0	2,331	74,768	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,994,487	704,507	0	136,863	517,643	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,206	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	337,972	0	0	303	44,912	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	NONPATIENT RELATED MEALS	0	0	0	0	0	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	24,097	0	0	0	194.03
194.04	07955	RETAIL PHARMACY	68,114	0	0	831	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	13,400,573	731,810	0	137,997	562,555	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/18/2016 12:44 pm

		Cost Center Description	ADMITTING	Subtotal	HOSPITAL ONLY A & G	Subtotal	SHARED ADMN & GENERAL	
			5.01	5A.01	5.02	5A.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	113,414					5.01
5.02	00590	HOSPITAL ONLY A & G	0	154,344	154,344			5.02
5.03	00591	SHARED ADMN & GENERAL	0	2,483,798	34,508	2,518,306	2,518,306	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	609,196	8,464	617,660	143,252	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	33,736	469	34,205	7,933	8.00
9.00	00900	HOUSEKEEPING	0	206,515	2,869	209,384	48,562	9.00
10.00	01000	DIETARY	0	139,101	1,933	141,034	32,710	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	95,264	1,324	96,588	22,401	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	181,176	2,517	183,693	42,603	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	162,231	2,254	164,485	38,149	16.00
17.00	01700	SOCIAL SERVICE	0	72,943	1,013	73,956	17,152	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	217,284	3,019	220,303	51,094	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,552	1,129,923	15,699	1,145,622	265,701	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,605	382,170	5,310	387,480	89,867	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,185	926,390	12,871	939,261	217,840	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	26,879	1,065,043	14,798	1,079,841	250,444	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	298	17,335	241	17,576	4,076	63.00
65.00	06500	RESPIRATORY THERAPY	3,828	229,633	3,191	232,824	53,998	65.00
66.00	06600	PHYSICAL THERAPY	6,493	463,988	6,447	470,435	109,107	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	877	41,214	573	41,787	9,692	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,107	115,734	1,608	117,342	27,215	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,653	616,448	8,565	625,013	144,957	73.00
76.00	03950	SLEEP LAB	1,606	49,530	688	50,218	11,647	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,658,075	0	1,658,075	384,552	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	15,331	1,870,067	25,983	1,896,050	439,749	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	113,414	12,921,138	154,344	12,921,138	2,412,701	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,206	0	3,206	744	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	383,187	0	383,187	88,871	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	NONPATIENT RELATED MEALS	0	0	0	0	0	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	24,097	0	24,097	0	194.03
194.04	07955	RETAIL PHARMACY	0	68,945	0	68,945	15,990	194.04
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	113,414	13,400,573	154,344	13,400,573	2,518,306	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/18/2016 12:44 pm

		Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS	760,912					6.00
7.00	00700	OPERATION OF PLANT	0	0				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,537	0	44,675			8.00
9.00	00900	HOUSEKEEPING	12,257	0	0	270,203		9.00
10.00	01000	DIETARY	38,800	0	0	16,351	228,895	10.00
11.00	01100	CAFETERIA	0	0	0	0	129,044	11.00
13.00	01300	NURSING ADMINISTRATION	1,971	0	0	831	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	32,691	0	0	13,776	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,255	0	0	1,793	0	16.00
17.00	01700	SOCIAL SERVICE	2,928	0	0	1,234	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,093	0	0	461	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	180,963	0	23,423	76,258	66,297	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	98,795	0	3,162	41,633	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	84,997	0	3,965	35,818	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	33,062	0	0	13,932	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	6,206	0	0	2,615	0	65.00
66.00	06600	PHYSICAL THERAPY	46,353	0	387	19,533	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,554	0	0	4,869	0	73.00
76.00	03950	SLEEP LAB	16,492	0	64	6,950	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	104,924	0	842	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	46,294	0	12,832	19,509	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	726,172	0	44,675	255,563	195,341	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,079	0	0	1,719	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	NONPATIENT RELATED MEALS	0	0	0	0	33,554	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	30,661	0	0	12,921	0	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0	0	194.04
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)	760,912	0	44,675	270,203	228,895	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/18/2016 12:44 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	14.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
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	129,044					11.00
13.00	01300	NURSING ADMINISTRATION	0	121,791				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	272,763			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	208,682		16.00
17.00	01700	SOCIAL SERVICE	1,826	0	0	0	97,096	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,880	62,508	29,705	13,895	97,096	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,256	11,914	22,077	15,833	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,846	23	18,911	51,870	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	15,381	0	24,314	49,454	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	151	0	0	549	0	63.00
65.00	06500	RESPIRATORY THERAPY	6,384	328	10,519	7,043	0	65.00
66.00	06600	PHYSICAL THERAPY	7,121	23	3,182	11,946	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	31,273	1,613	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	94,058	3,877	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,473	0	1,464	21,440	0	73.00
76.00	03950	SLEEP LAB	754	0	583	2,954	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	24,562	0	7,450	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	18,681	46,995	20,181	28,208	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	120,315	121,791	263,717	208,682	97,096	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,729	0	9,046	0	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	NONPATIENT RELATED MEALS	0	0	0	0	0	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0	0	194.04
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)	129,044	121,791	272,763	208,682	97,096	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/18/2016 12:44 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
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
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	272,951					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,986,348	0	1,986,348		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	272,951	947,968	0	947,968		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,364,531	0	1,364,531		54.00
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	1,466,428	0	1,466,428		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	22,352	0	22,352		63.00
65.00	06500	RESPIRATORY THERAPY	0	319,917	0	319,917		65.00
66.00	06600	PHYSICAL THERAPY	0	668,087	0	668,087		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	84,365	0	84,365		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	242,492	0	242,492		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	813,770	0	813,770		73.00
76.00	03950	SLEEP LAB	0	89,662	0	89,662		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,180,405	0	2,180,405		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	2,528,499	0	2,528,499		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04040	INFUSION CENTER	0	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	272,951	12,714,824	0	12,714,824		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,748	0	9,748		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	489,833	0	489,833		192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0		194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0		194.01
194.02	07952	NONPATIENT RELATED MEALS	0	33,554	0	33,554		194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	67,679	0	67,679		194.03
194.04	07955	RETAIL PHARMACY	0	84,935	0	84,935		194.04
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	272,951	13,400,573	0	13,400,573		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/18/2016 12:44 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
				BLDG & FIXT	FOUNDATION BLDG	MVBLE EQUIP		
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00570	ADMITTING	0	0	0	954	954	5.01
5.02	00590	HOSPITAL ONLY A & G	0	859	0	0	859	5.02
5.03	00591	SHARED ADMN & GENERAL	0	148,165	0	6,723	154,888	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	67,244	0	12,520	79,764	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,994	0	0	1,994	8.00
9.00	00900	HOUSEKEEPING	0	9,633	0	0	9,633	9.00
10.00	01000	DIETARY	0	30,493	0	1,864	32,357	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,549	0	0	1,549	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	25,692	0	0	25,692	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,344	0	0	3,344	16.00
17.00	01700	SOCIAL SERVICE	0	2,301	0	0	2,301	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	859	0	0	859	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	142,218	0	6,302	148,520	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	77,643	0	24,371	102,014	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	66,799	0	73,347	140,146	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	25,983	0	1,086	27,069	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	4,878	0	0	4,878	65.00
66.00	06600	PHYSICAL THERAPY	0	36,429	0	4,563	40,992	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,556	2,556	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	9,080	0	0	9,080	73.00
76.00	03950	SLEEP LAB	0	12,961	0	90	13,051	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	156	156	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	36,383	0	2,331	38,714	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	704,507	0	136,863	841,370	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,206	0	0	3,206	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	303	303	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	NONPATIENT RELATED MEALS	0	0	0	0	0	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	24,097	0	0	24,097	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	831	831	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	731,810	0	137,997	869,807	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/18/2016 12:44 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	HOSPITAL ONLY A & G	SHARED ADMN & GENERAL	MAINTENANCE & REPAIRS	
			4.00	5.01	5.02	5.03	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.01	00570	ADMITTING	0	954				5.01
5.02	00590	HOSPITAL ONLY A & G	0	0	859			5.02
5.03	00591	SHARED ADMN & GENERAL	0	0	195	155,083		5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	47	8,822	88,633	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	3	489	296	8.00
9.00	00900	HOUSEKEEPING	0	0	16	2,991	1,428	9.00
10.00	01000	DIETARY	0	0	11	2,014	4,520	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	7	1,380	230	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14	2,624	3,808	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	12	2,349	496	16.00
17.00	01700	SOCIAL SERVICE	0	0	6	1,056	341	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	17	3,147	127	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	64	87	16,363	21,076	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	73	29	5,534	11,508	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	234	71	13,415	9,901	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	227	82	15,423	3,851	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	3	1	251	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	32	18	3,325	723	65.00
66.00	06600	PHYSICAL THERAPY	0	55	36	6,719	5,399	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7	3	597	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18	9	1,676	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	98	47	8,927	1,346	73.00
76.00	03950	SLEEP LAB	0	14	4	717	1,921	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	23,682	12,222	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	129	144	27,078	5,393	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	954	859	148,579	84,586	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	46	475	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	5,473	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	NONPATIENT RELATED MEALS	0	0	0	0	0	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	3,572	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	985	0	194.04
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)	0	954	859	155,083	88,633	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/18/2016 12:44 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	0					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,782				8.00
9.00	00900	HOUSEKEEPING	0	0	14,068			9.00
10.00	01000	DIETARY	0	0	851	39,753		10.00
11.00	01100	CAFETERIA	0	0	0	22,411	22,411	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	43	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	717	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	93	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	64	0	317	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	24	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,459	3,971	11,514	4,321	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	197	2,168	0	739	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	247	1,865	0	2,057	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	725	0	2,671	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	26	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	136	0	1,109	65.00
66.00	06600	PHYSICAL THERAPY	0	24	1,017	0	1,237	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	254	0	777	73.00
76.00	03950	SLEEP LAB	0	4	362	0	131	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	52	0	0	4,266	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	799	1,016	0	3,244	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,782	13,306	33,925	20,895	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	89	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,516	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	NONPATIENT RELATED MEALS	0	0	0	5,828	0	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	673	0	0	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0	0	194.04
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)	0	2,782	14,068	39,753	22,411	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/18/2016 12:44 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
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
13.00	01300	NURSING ADMINISTRATION	3,209					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	32,855				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	6,294			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	4,085		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	4,174	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,646	3,578	419	4,085		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	314	2,659	478	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1	2,278	1,561	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	2,929	1,492	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	17	0		63.00
65.00	06500	RESPIRATORY THERAPY	9	1,267	213	0		65.00
66.00	06600	PHYSICAL THERAPY	1	383	361	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,767	49	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,330	117	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	176	647	0		73.00
76.00	03950	SLEEP LAB	0	70	89	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	897	0	0		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	1,238	2,431	851	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,209	31,765	6,294	4,085	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,090	0	0		192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0		194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0		194.01
194.02	07952	NONPATIENT RELATED MEALS	0	0	0	0		194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0		194.04
200.00		Cross Foot Adjustments					4,174	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,209	32,855	6,294	4,085	4,174	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/18/2016 12:44 pm

		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
1.01	00101	FOUNDATION BLDG					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00590	HOSPITAL ONLY A & G					5.02
5.03	00591	SHARED ADMN & GENERAL					5.03
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
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	217,103	0	217,103		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	125,713	0	125,713		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	171,776	0	171,776		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	54,469	0	54,469		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	298	0	298		63.00
65.00	06500	RESPIRATORY THERAPY	11,710	0	11,710		65.00
66.00	06600	PHYSICAL THERAPY	56,224	0	56,224		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,979	0	6,979		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,150	0	13,150		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,352	0	21,352		73.00
76.00	03950	SLEEP LAB	16,363	0	16,363		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	41,275	0	41,275		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	81,037	0	81,037		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
93.00	04040	INFUSION CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	817,449	0	817,449		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,816	0	3,816		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,382	0	8,382		192.00
194.00	07950	BOARD OF HEALTH	0	0	0		194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0		194.01
194.02	07952	NONPATIENT RELATED MEALS	5,828	0	5,828		194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	28,342	0	28,342		194.03
194.04	07955	RETAIL PHARMACY	1,816	0	1,816		194.04
200.00		Cross Foot Adjustments	4,174	0	4,174		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	869,807	0	869,807		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/18/2016 12:44 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	FOUNDATION BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHAR GES)	
			1.00	1.01	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	47,711					1.00
1.01	00101	FOUNDATION BLDG	0	0				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			234,871			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	5,320,307		4.00
5.01	00570	ADMITTING	0	0	1,624	93,506	20,381,274	5.01
5.02	00590	HOSPITAL ONLY A & G	56	0	0	0	0	5.02
5.03	00591	SHARED ADMN & GENERAL	9,660	0	11,442	468,591	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	4,384	0	21,309	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	130	0	0	26,863	0	8.00
9.00	00900	HOUSEKEEPING	628	0	0	0	0	9.00
10.00	01000	DIETARY	1,988	0	3,173	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	101	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,675	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	218	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	150	0	0	59,056	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	56	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,272	0	10,726	701,701	1,357,051	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,062	0	41,480	152,453	1,546,304	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,355	0	124,838	414,412	5,066,153	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,694	0	1,848	391,266	4,830,007	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	4,344	53,626	63.00
65.00	06500	RESPIRATORY THERAPY	318	0	0	172,967	687,839	65.00
66.00	06600	PHYSICAL THERAPY	2,375	0	7,767	286,131	1,166,720	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	4,350	0	157,523	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	378,659	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	592	0	0	233,599	2,093,968	73.00
76.00	03950	SLEEP LAB	845	0	153	25,290	288,502	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	265	1,158,264	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,372	0	3,967	707,115	2,754,922	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	45,931	0	232,942	4,895,558	20,381,274	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	209	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	515	424,749	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	NONPATIENT RELATED MEALS	0	0	0	0	0	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	1,571	0	0	0	0	194.03
194.04	07955	RETAIL PHARMACY	0	0	1,414	0	0	194.04
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)	731,810	0	137,997	562,555	113,414	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.338392	0.000000	0.587544	0.105737	0.005565	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0	954	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000	0.000047	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/18/2016 12:44 pm

		Cost Center Description	Reconciliation	HOSPITAL ONLY A & G (ACCUM. COST)	Reconciliation	SHARED ADMN & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			5A.02	5.02	5A.03	5.03	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G	-154,344	11,108,719				5.02
5.03	00591	SHARED ADMN & GENERAL	0	2,483,798	-2,518,306	10,858,170		5.03
6.00	00600	MAINTENANCE & REPAIRS	0	609,196	0	617,660	38,987	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	33,736	0	34,205	130	8.00
9.00	00900	HOUSEKEEPING	0	206,515	0	209,384	628	9.00
10.00	01000	DIETARY	0	139,101	0	141,034	1,988	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	95,264	0	96,588	101	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	181,176	0	183,693	1,675	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	162,231	0	164,485	218	16.00
17.00	01700	SOCIAL SERVICE	0	72,943	0	73,956	150	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	217,284	0	220,303	56	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,129,923	0	1,145,622	9,272	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	382,170	0	387,480	5,062	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	926,390	0	939,261	4,355	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,065,043	0	1,079,841	1,694	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	17,335	0	17,576	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	229,633	0	232,824	318	65.00
66.00	06600	PHYSICAL THERAPY	0	463,988	0	470,435	2,375	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	41,214	0	41,787	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	115,734	0	117,342	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	616,448	0	625,013	592	73.00
76.00	03950	SLEEP LAB	0	49,530	0	50,218	845	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	-1,658,075	0	0	1,658,075	5,376	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	1,870,067	0	1,896,050	2,372	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,812,419	11,108,719	-2,518,306	10,402,832	37,207	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-3,206	0	0	3,206	209	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-383,187	0	0	383,187	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	NONPATIENT RELATED MEALS	0	0	0	0	0	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	-24,097	0	-24,097	0	1,571	194.03
194.04	07955	RETAIL PHARMACY	-68,945	0	0	68,945	0	194.04
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)		154,344		2,518,306	760,912	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.013894		0.231927	19.517070	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		859		155,083	88,633	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000077		0.014283	2.273399	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/18/2016 12:44 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	0					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	35,862				8.00
9.00	00900	HOUSEKEEPING	0	0	32,853			9.00
10.00	01000	DIETARY	0	0	1,988	21,147		10.00
11.00	01100	CAFETERIA	0	0	0	11,922	7,702	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	101	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,675	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	218	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	150	0	109	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	56	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	18,802	9,272	6,125	1,485	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,538	5,062	0	254	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,183	4,355	0	707	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	1,694	0	918	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	9	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	318	0	381	65.00
66.00	06600	PHYSICAL THERAPY	0	311	2,375	0	425	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	592	0	267	73.00
76.00	03950	SLEEP LAB	0	51	845	0	45	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	676	0	0	1,466	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	10,301	2,372	0	1,115	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	35,862	31,073	18,047	7,181	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	209	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	521	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	NONPATIENT RELATED MEALS	0	0	0	3,100	0	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	1,571	0	0	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0	0	194.04
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)	0	44,675	270,203	228,895	129,044	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	1.245748	8.224607	10.823994	16.754609	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	2,782	14,068	39,753	22,411	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.077575	0.428211	1.879841	2.909764	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/18/2016 12:44 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
			13.00	14.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
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
13.00	01300	NURSING ADMINISTRATION	53,905					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	329,515				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	20,381,274			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	237		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,667	35,886	1,357,051	237	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,273	26,670	1,546,304	0	100	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10	22,846	5,066,153	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	29,373	4,830,007	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	53,626	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	145	12,708	687,839	0	0	65.00
66.00	06600	PHYSICAL THERAPY	10	3,844	1,166,720	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	37,780	157,523	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	113,627	378,659	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,769	2,093,968	0	0	73.00
76.00	03950	SLEEP LAB	0	704	288,502	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	9,000	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	20,800	24,380	2,754,922	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	53,905	318,587	20,381,274	237	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,928	0	0	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	NONPATIENT RELATED MEALS	0	0	0	0	0	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0	0	194.04
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)	121,791	272,763	208,682	97,096	272,951	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.259364	0.827771	0.010239	409.687764	2,729.510000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,209	32,855	6,294	4,085	4,174	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.059531	0.099707	0.000309	17.236287	41.740000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/18/2016 12:44 pm

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		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	1,986,348		1,986,348	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	947,968		947,968	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,364,531		1,364,531	0	0	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	1,466,428		1,466,428	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	22,352		22,352	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	319,917	0	319,917	0	0	65.00
66.00	06600	PHYSICAL THERAPY	668,087	0	668,087	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	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	84,365		84,365	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	242,492		242,492	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	813,770		813,770	0	0	73.00
76.00	03950	SLEEP LAB	89,662		89,662	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,180,405		2,180,405	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,528,499		2,528,499	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	284,774		284,774		0	92.00
93.00	04040	INFUSION CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0		0		0	117.00
200.00		Subtotal (see instructions)	12,999,598	0	12,999,598	0	0	200.00
201.00		Less Observation Beds	284,774		284,774		0	201.00
202.00		Total (see instructions)	12,714,824	0	12,714,824	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/18/2016 12:44 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,357,051		1,357,051			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,707	1,525,597	1,546,304	0.613054	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	147,746	4,918,407	5,066,153	0.269343	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	372,693	4,457,314	4,830,007	0.303608	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,783	46,843	53,626	0.416813	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	251,894	435,945	687,839	0.465104	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	274,742	891,978	1,166,720	0.572620	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	44,887	112,636	157,523	0.535573	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,632	367,027	378,659	0.640397	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	599,003	1,494,966	2,093,969	0.388626	0.000000	73.00
76.00	03950	SLEEP LAB	0	288,502	288,502	0.310785	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,015,084	4,015,084			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	27,337	2,727,585	2,754,922	0.917811	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,843	235,024	240,867	1.182287	0.000000	92.00
93.00	04040	INFUSION CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117.00
200.00		Subtotal (see instructions)	3,120,318	21,516,908	24,637,226			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,120,318	21,516,908	24,637,226			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/18/2016 12:44 pm

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	05600	RADIOISOTOPE	0.000000		56.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	SLEEP LAB	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04040	INFUSION CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS			117.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/18/2016 12:44 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,986,348		1,986,348	0	1,986,348	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	947,968		947,968	0	947,968	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,364,531		1,364,531	0	1,364,531	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	1,466,428		1,466,428	0	1,466,428	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	22,352		22,352	0	22,352	63.00
65.00	06500	RESPIRATORY THERAPY	319,917	0	319,917	0	319,917	65.00
66.00	06600	PHYSICAL THERAPY	668,087	0	668,087	0	668,087	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	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	84,365		84,365	0	84,365	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	242,492		242,492	0	242,492	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	813,770		813,770	0	813,770	73.00
76.00	03950	SLEEP LAB	89,662		89,662	0	89,662	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,180,405		2,180,405	0	2,180,405	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,528,499		2,528,499	0	2,528,499	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	284,774		284,774		284,774	92.00
93.00	04040	INFUSION CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0		0		0	117.00
200.00		Subtotal (see instructions)	12,999,598	0	12,999,598	0	12,999,598	200.00
201.00		Less Observation Beds	284,774		284,774		284,774	201.00
202.00		Total (see instructions)	12,714,824	0	12,714,824	0	12,714,824	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/18/2016 12:44 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,357,051		1,357,051			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,707	1,525,597	1,546,304	0.613054	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	147,746	4,918,407	5,066,153	0.269343	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	372,693	4,457,314	4,830,007	0.303608	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,783	46,843	53,626	0.416813	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	251,894	435,945	687,839	0.465104	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	274,742	891,978	1,166,720	0.572620	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	44,887	112,636	157,523	0.535573	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,632	367,027	378,659	0.640397	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	599,003	1,494,966	2,093,969	0.388626	0.000000	73.00
76.00	03950	SLEEP LAB	0	288,502	288,502	0.310785	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,015,084	4,015,084	0.543053	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	27,337	2,727,585	2,754,922	0.917811	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,843	235,024	240,867	1.182287	0.000000	92.00
93.00	04040	INFUSION CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117.00
200.00		Subtotal (see instructions)	3,120,318	21,516,908	24,637,226			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,120,318	21,516,908	24,637,226			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/18/2016 12:44 pm

Title XIX | 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	05600	RADIOISOTOPE	0.000000		56.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	SLEEP LAB	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04040	INFUSION CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS			117.00
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: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/18/2016 12:44 pm

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	125,713	1,546,304	0.081299	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	171,776	5,066,153	0.033907	60,571	2,054	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	54,469	4,830,007	0.011277	157,402	1,775	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	298	53,626	0.005557	5,521	31	63.00
65.00	06500	RESPIRATORY THERAPY	11,710	687,839	0.017024	98,163	1,671	65.00
66.00	06600	PHYSICAL THERAPY	56,224	1,166,720	0.048190	17,780	857	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,979	157,523	0.044305	14,834	657	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,150	378,659	0.034728	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,352	2,093,969	0.010197	176,762	1,802	73.00
76.00	03950	SLEEP LAB	16,363	288,502	0.056717	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	41,275	4,015,084	0.010280	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	81,037	2,754,922	0.029415	9,233	272	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	31,125	240,867	0.129221	2,041	264	92.00
93.00	04040	INFUSION CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	631,471	23,280,175		542,307	9,383	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/18/2016 12:44 pm

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	272,951	0	0	0	272,951	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	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
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
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	272,951	0	0	0	272,951	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/18/2016 12:44 pm

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	1,546,304	0.176518	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,066,153	0.000000	0.000000	60,571	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	4,830,007	0.000000	0.000000	157,402	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	53,626	0.000000	0.000000	5,521	63.00
65.00	06500	RESPIRATORY THERAPY	0	687,839	0.000000	0.000000	98,163	65.00
66.00	06600	PHYSICAL THERAPY	0	1,166,720	0.000000	0.000000	17,780	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	157,523	0.000000	0.000000	14,834	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	378,659	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,093,969	0.000000	0.000000	176,762	73.00
76.00	03950	SLEEP LAB	0	288,502	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,015,084	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	2,754,922	0.000000	0.000000	9,233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	240,867	0.000000	0.000000	2,041	92.00
93.00	04040	INFUSION CENTER	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	23,280,175			542,307	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/18/2016 12:44 pm

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	05600	RADIOISOTOPE	0	0	0		56.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
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
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
93.00	04040	INFUSION CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/18/2016 12:44 pm

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	0.613054	0	539,653	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269343	0	1,546,061	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.303608	0	1,516,238	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.416813	0	26,298	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.465104	0	149,046	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.572620	0	357,086	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.535573	0	42,239	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.640397	0	157,272	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.388626	0	716,896	2,455	0	73.00
76.00	03950	SLEEP LAB	0.310785	0	61,564	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.917811	0	723,261	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.182287	0	103,234	0	0	92.00
93.00	04040	INFUSION CENTER	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	5,938,848	2,455	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	5,938,848	2,455	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/18/2016 12:44 pm

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	330,836	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	416,421	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	460,342	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	10,961	0		63.00
65.00	06500	RESPIRATORY THERAPY	69,322	0		65.00
66.00	06600	PHYSICAL THERAPY	204,475	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,622	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100,717	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	278,604	954		73.00
76.00	03950	SLEEP LAB	19,133	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	663,817	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	122,052	0		92.00
93.00	04040	INFUSION CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	2,699,302	954		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	2,699,302	954		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141304 | Component CCN: 14Z304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/18/2016 12:44 pm

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	0.613054	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269343	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.303608	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.416813	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.465104	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.572620	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.535573	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.640397	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.388626	0	0	0	0	73.00
76.00	03950	SLEEP LAB	0.310785	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.917811	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.182287	0	0	0	0	92.00
93.00	04040	INFUSION CENTER	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		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: 141304 | Component CCN: 14Z304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/18/2016 12:44 pm

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	05600	RADIOISOTOPE	0	0		56.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	SLEEP LAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04040	INFUSION CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141304	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/18/2016 12:44 pm
	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)	1,588	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	706	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)	481	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	413	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)	448	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	10	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)	11	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	306	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)	315	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)	341	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	142.80	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	148.51	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,986,348	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)	1,428	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)	1,634	25.00
26.00	Total swing-bed cost (see instructions)	1,092,795	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	893,553	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)	893,553	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,265.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	387,292	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)	387,292	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/18/2016 12:44 pm

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)	209,767	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	597,059	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)	398,683	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	431,590	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	830,273	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)	225	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,265.66	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	284,774	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/18/2016 12:44 pm

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	217,103	1,986,348	0.109298	284,774	31,125	90.00
91.00	Nursing School cost	0	1,986,348	0.000000	284,774	0	91.00
92.00	Allied health cost	0	1,986,348	0.000000	284,774	0	92.00
93.00	All other Medical Education	0	1,986,348	0.000000	284,774	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/18/2016 12:44 pm

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		285,617		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.613054	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269343	60,571	16,314	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.303608	157,402	47,789	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.416813	5,521	2,301	63.00
65.00	06500	RESPIRATORY THERAPY	0.465104	98,163	45,656	65.00
66.00	06600	PHYSICAL THERAPY	0.572620	17,780	10,181	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.535573	14,834	7,945	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.640397	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.388626	176,762	68,694	73.00
76.00	03950	SLEEP LAB	0.310785	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.917811	9,233	8,474	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.182287	2,041	2,413	92.00
93.00	04040	INFUSION CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		542,307	209,767	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)		542,307		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141304 | Component CCN: 14Z304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/18/2016 12:44 pm

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	0.613054	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269343	24,774	6,673	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.303608	87,932	26,697	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.416813	394	164	63.00
65.00	06500	RESPIRATORY THERAPY	0.465104	75,270	35,008	65.00
66.00	06600	PHYSICAL THERAPY	0.572620	185,602	106,279	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.535573	22,275	11,930	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.640397	11,632	7,449	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.388626	231,775	90,074	73.00
76.00	03950	SLEEP LAB	0.310785	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.917811	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.182287	0	0	92.00
93.00	04040	INFUSION CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		639,654	284,274	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)		639,654		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141304	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/18/2016 12:44 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,700,256	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)	2,700,256	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)	2,727,259	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)	17,945	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	888,094	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)	1,821,220	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)	1,821,220	30.00
31.00	Primary payer payments	1,720	31.00
32.00	Subtotal (line 30 minus line 31)	1,819,500	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)	116,452	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	75,694	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	115,344	36.00
37.00	Subtotal (see instructions)	1,895,194	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,895,194	40.00
40.01	Sequestration adjustment (see instructions)	37,904	40.01
41.00	Interim payments	1,931,198	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-73,908	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: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/18/2016 12:44 pm

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		508,363		1,821,753	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	02/17/2016	26,024	06/21/2016	218,319	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	06/21/2016	12,764	02/17/2016	108,874	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)		13,260		109,445	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)		521,623		1,931,198	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		14,059		73,908	6.02
7.00	Total Medicare program liability (see instructions)		507,564		1,857,290	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: 141304 | Component CCN: 14Z304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/18/2016 12:44 pm

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		956,596		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	02/17/2016	55,610		0	3.01
3.02		06/21/2016	120,576		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		176,186		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)		1,132,782		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		50,694		0	6.02
7.00	Total Medicare program liability (see instructions)		1,082,088		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: 141304	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/18/2016 12:44 pm
	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	237	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	306	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	96	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	481	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	24,637,226	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	313,348	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	64,709	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	64,709	8.00
9.00	Sequestration adjustment amount (see instructions)	1,294	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	63,415	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)	63,415	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141304 Component CCN: 14Z304	Period: From 07/01/2015 To 06/30/2016	Worksheet E-2 Date/Time Prepared: 11/18/2016 12:44 pm
	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)	838,576	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)	287,117	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	656	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)	1,125,693	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,125,693	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)	1,125,693	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	21,522	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)	1,104,171	0	15.00
16.00	OTHER	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)	1,104,171	0	19.00
19.01	Sequestration adjustment (see instructions)	22,083	0	19.01
20.00	Interim payments	1,132,782	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)	-50,694	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: 141304	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part V Date/Time Prepared: 11/18/2016 12:44 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	597,059	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)	597,059	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	603,030	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)	603,030	19.00
20.00	Deductibles (exclude professional component)	93,773	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	509,257	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	509,257	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	13,330	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	8,665	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	13,330	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	517,922	28.00
29.00	OTHER	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)	517,922	30.00
30.01	Sequestration adjustment (see instructions)	10,358	30.01
31.00	Interim payments	521,623	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)	-14,059	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: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G | Date/Time Prepared: 11/18/2016 12:44 pm

		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	247,533	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	3,629,094	0	0	0	4.00
5.00	Other receivable	23,716	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,677,520	0	0	0	6.00
7.00	Inventory	154,803	0	0	0	7.00
8.00	Prepaid expenses	66,198	0	0	0	8.00
9.00	Other current assets	230,906	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)	2,674,730	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	65,000	0	0	0	12.00
13.00	Land improvements	148,361	0	0	0	13.00
14.00	Accumulated depreciation	-15,878	0	0	0	14.00
15.00	Buildings	12,061,638	0	0	0	15.00
16.00	Accumulated depreciation	-1,146,692	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	1,859,377	0	0	0	19.00
20.00	Accumulated depreciation	-406,025	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	109,793	0	0	0	23.00
24.00	Accumulated depreciation	-78,855	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,596,719	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,448,634	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	597,071	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,045,705	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	17,317,154	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	515,616	0	0	0	37.00
38.00	Salaries, wages, and fees payable	466,976	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,402,891	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	453,350	0	0	0	43.00
44.00	Other current liabilities	132,717	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,971,550	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,859,887	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,859,887	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,831,437	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	5,485,717				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)	5,485,717	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	17,317,154	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-1 | Date/Time Prepared: 11/18/2016 12:44 pm

		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		5,810,848		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-548,656				2.00
3.00	Total (sum of line 1 and line 2)		5,262,192		0		3.00
4.00	TEMPORARY RESTRICTED ASSETS	223,525		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)		223,525		0		10.00
11.00	Subtotal (line 3 plus line 10)		5,485,717		0		11.00
12.00		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)		5,485,717		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	TEMPORARY RESTRICTED ASSETS		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			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: 141304 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/18/2016 12:44 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	485,172		485,172	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	714,840		714,840	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,200,012		1,200,012	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)	1,200,012		1,200,012	17.00
18.00	Ancillary services	1,735,839	17,094,522	18,830,361	18.00
19.00	Outpatient services	56,340	490,003	546,343	19.00
20.00	RURAL HEALTH CLINIC	0	5,273,785	5,273,785	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	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	20,189	1,721,703	1,741,892	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,012,380	24,580,013	27,592,393	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		14,794,543		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		14,794,543		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141304	Period: From 07/01/2015 To 06/30/2016	Worksheet G-3 Date/Time Prepared: 11/18/2016 12:44 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	27,592,393	1.00
2.00	Less contractual allowances and discounts on patients' accounts	13,998,324	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,594,069	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,794,543	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,200,474	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	843	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	355,547	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	638	21.00
22.00	Rental of hospital space	5,404	22.00
23.00	Governmental appropriations	22,790	23.00
24.00	INTERCOMPANY REVENUE	183,671	24.00
24.01	OTHER REVENUE	82,925	24.01
24.02		0	24.02
24.03		0	24.03
25.00	Total other income (sum of lines 6-24)	651,818	25.00
26.00	Total (line 5 plus line 25)	-548,656	26.00
27.00	RECONCILING ITEM	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-548,656	29.00

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

Provider CCN: 141304 Component CCN: 143453 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-1 | Date/Time Prepared: 11/18/2016 12:44 pm

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	558,262	34,660	592,922	0	592,922	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	300,350	18,647	318,997	0	318,997	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	241,089	14,968	256,057	0	256,057	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	378	23	401	0	401	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	70,291	4,364	74,655	0	74,655	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,170,370	72,662	1,243,032	0	1,243,032	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	69,013	69,013	0	69,013	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	69,013	69,013	0	69,013	14.00
15.00	Medical Supplies	0	9,524	9,524	-524	9,000	15.00
16.00	Transportation (Health Care Staff)	0	1,595	1,595	0	1,595	16.00
17.00	Depreciation-Medical Equipment	0	5,678	5,678	0	5,678	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	16,797	16,797	-524	16,273	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,170,370	158,472	1,328,842	-524	1,328,318	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	3,737	3,737	0	3,737	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	3,737	3,737	0	3,737	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	88,252	88,252	0	88,252	29.00
30.00	Administrative Costs	221,871	167,743	389,614	-174,790	214,824	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	221,871	255,995	477,866	-174,790	303,076	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,392,241	418,204	1,810,445	-175,314	1,635,131	32.00

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

Provider CCN: 141304 | Component CCN: 143453 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-1 | Date/Time Prepared: 11/18/2016 12:44 pm

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	-97,497	495,425		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	318,997		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	256,057		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	401		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	74,655		9.00
10.00	Subtotal (sum of lines 1 through 9)	-97,497	1,145,535		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	69,013		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	69,013		14.00
15.00	Medical Supplies	0	9,000		15.00
16.00	Transportation (Health Care Staff)	0	1,595		16.00
17.00	Depreciation-Medical Equipment	0	5,678		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	16,273		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-97,497	1,230,821		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	3,737		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	3,737		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	88,252		29.00
30.00	Administrative Costs	-2,189	212,635		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-2,189	300,887		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-99,686	1,535,445		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141304 | Component CCN: 143453 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-2 | Date/Time Prepared: 11/18/2016 12:44 pm

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	2.63	10,688	4,200	11,046		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.80	6,522	2,100	3,780		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.43	17,210		14,826	17,210	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	0.30	506			506	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.73	17,716			17,716	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,230,821	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	3,737	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,234,558	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)	0.996973	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)	300,887	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	644,960	15.00
16.00	Total overhead (sum of lines 14 and 15)	945,847	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtotal (see instructions)	945,847	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	942,984	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	2,173,805	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141304 Component CCN: 143453	Period: From 07/01/2015 To 06/30/2016	Worksheet M-3 Date/Time Prepared: 11/18/2016 12:44 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		2,173,805	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		632	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,173,173	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		17,716	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)		17,716	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		122.67	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)	122.67	122.67	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,639	1,545	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	201,056	189,525	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) *		390,581	16.00
16.01	Total program charges (see instructions)(from contractor's records)		638,862	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	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.)		272,970	16.04
16.05	Total program cost (see instructions)		272,970	16.05
17.00	Primary payer amounts		591	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		49,368	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		117,899	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		272,379	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		83	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		272,462	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	SEQUESTRATION RECONCILIATION TO PS&R		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		272,462	26.00
26.01	Sequestration adjustment (see instructions)		5,449	26.01
27.00	Interim payments		284,526	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)		-17,513	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: 141304 | Component CCN: 143453 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-4 | Date/Time Prepared: 11/18/2016 12:44 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,145,535	1,145,535	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000128	0.000128	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	147	147	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	63	0	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	210	147	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,230,821	1,230,821	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	945,847	945,847	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000171	0.000119	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	162	113	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	372	260	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	9	0	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	41.33	0.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	2	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	83	0	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)		632	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)		83	16.00

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

Provider CCN: 141304 | Component CCN: 143453 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-5 | Date/Time Prepared: 11/18/2016 12:44 pm

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		309,632	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		02/17/2016	25,106	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)		-25,106	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		284,526	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		17,513	6.02
7.00	Total Medicare program liability (see instructions)		267,013	7.00

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