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
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1310	Period: From 10/01/2015 To 09/30/2016	Worksheet S Parts I-III Date/Time Prepared: 2/27/2017 4:17 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/27/2017 Time: 4:17 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 MENDOTA COMMUNITY HOSPITAL (14-1310) for the cost reporting period beginning 10/01/2015 and ending 09/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	157,649	-149,770	0	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	-25,438	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		160,494		0	10.00
200.00	Total	0	132,211	10,724	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2017 4:11 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1401 EAST 12TH ST	PO Box:			1.00
2.00	City: MENDOTA	State: IL	Zip Code: 61342-9216	County: LASALLE	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	MENDOTA COMMUNITY HOSPITAL	141310	99914	1	01/15/2001	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MENDOTA COMMUNITY SWING BED- SNF	14Z310	99914		01/25/2001	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	MENDOTA COMMUNITY HOSPITAL - HHA	147616	99914		09/15/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	MENDOTA COMMUNITY HOSPITAL - RHC	148535	99914		02/11/2015	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:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2015	09/30/2016	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.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2017 4:11 pm

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2017 4:11 pm

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

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		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	Y	N	109.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	491,137	0	0	118.01

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		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.	N		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	149006	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: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS	Contractor's Number: 00131	141.00
142.00	Street: 800 N.E. GLEN OAK AVENUE	PO Box:		142.00
143.00	City: PEORIA	State: IL	Zip Code: 61603	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.	Y	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2017 4:11 pm

							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.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
						Beginning	Ending	
						1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
						1.00	2.00	
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 in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 2/27/2017 4:11 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)	N			3.00

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	02/02/2017	Y	02/02/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 2/27/2017 4:11 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.	Y	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?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		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.	PATTY	RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544	STLHEALTHCARE@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1310	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Prepared: 2/27/2017 4:11 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		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: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 2/27/2017 4:11 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	21	7,686	28,128.00	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)		21	7,686	28,128.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,464	2,280.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,150	30,408.00	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	101.00				0	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	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	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: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2017 4:11 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)	721	142	1,172			1.00
2.00	HMO and other (see instructions)	91	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	607	0	683			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	325			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,328	142	2,180			7.00
8.00	INTENSIVE CARE UNIT	70	0	95			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,398	142	2,275	0.00	209.34	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	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	4,490	0	11,976	0.00	4.88	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	214.22	27.00
28.00	Observation Bed Days		0	643			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: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2017 4:11 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	272	49	450	1.00
2.00	HMO and other (see instructions)			29	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	272	49	450	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	0.00					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	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1310 | Component CCN: 14-8535 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-8 | Date/Time Prepared: 2/27/2017 4:11 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1405 E. 12TH ST.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MENDOTA		IL	61342	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	08:00	11.00

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

				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number						14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		LASALLE COUNTY				2.00

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1310
Component CCN: 14-8535

Period:
From 10/01/2015
To 09/30/2016

Worksheet S-8

Date/Time Prepared:
2/27/2017 4:11 pm

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-10 | Date/Time Prepared: 2/27/2017 4:11 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)	0.431287	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	539,266	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,151,951	5.00
6.00	Medicaid charges	10,462,202	6.00
7.00	Medicaid cost (line 1 times line 6)	4,512,212	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)	2,820,995	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (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 , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,820,995	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	592,426	392,887	985,313	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	255,506	169,447	424,953	21.00
22.00	Partial payment by patients approved for charity care	18,238	0	18,238	22.00
23.00	Cost of charity care (line 21 minus line 22)	237,268	169,447	406,715	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,464,145	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	387,197	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,076,948	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	464,474	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	871,189	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,692,184	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/27/2017 4:11 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		0	0	2,321,000	2,321,000	1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS		0	0	10,180	10,180	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,598,493	2,598,493	-773,713	1,824,780	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	313,614	3,128,031	3,441,645	71,982	3,513,627	4.00
5.01	01140	BUSINESS OFFICE	240,246	333,285	573,531	0	573,531	5.01
5.02	00550	DATA PROCESSING	204,886	532,802	737,688	2,931	740,619	5.02
5.03	00570	ADMITTING	273,222	53,068	326,290	0	326,290	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	97,505	16,936	114,441	0	114,441	5.04
5.05	00590	OTHER A&G	914,857	2,160,821	3,075,678	-374,125	2,701,553	5.05
7.00	00700	OPERATION OF PLANT	307,056	636,376	943,432	475	943,907	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	69,083	69,083	0	69,083	8.00
9.00	00900	HOUSEKEEPING	343,977	48,356	392,333	0	392,333	9.00
10.00	01000	DIETARY	294,394	132,009	426,403	-301,424	124,979	10.00
11.00	01100	CAFETERIA	0	0	0	301,424	301,424	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	141,552	141,552	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	228,632	58,458	287,090	0	287,090	16.00
17.00	01700	SOCIAL SERVICE	115,486	1,493	116,979	0	116,979	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,517,712	208,153	1,725,865	0	1,725,865	30.00
31.00	03100	INTENSIVE CARE UNIT	210,744	52,906	263,650	0	263,650	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	425,356	539,755	965,111	-206,050	759,061	50.00
51.00	05100	RECOVERY ROOM	50,504	34,804	85,308	0	85,308	51.00
53.00	05300	ANESTHESIOLOGY	622,907	64,149	687,056	-13,226	673,830	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	639,337	1,221,543	1,860,880	-1,060,387	800,493	54.00
56.00	05600	RADIOISOTOPE	0	0	0	410,162	410,162	56.00
57.00	05700	CT SCAN	0	0	0	420,406	420,406	57.00
58.00	05800	MRI	0	492	492	154,015	154,507	58.00
60.00	06000	LABORATORY	655,086	802,934	1,458,020	0	1,458,020	60.00
64.00	06400	INTRAVENOUS THERAPY	351,943	66,424	418,367	-26,067	392,300	64.00
65.00	06500	RESPIRATORY THERAPY	467,655	56,410	524,065	-10,779	513,286	65.00
66.00	06600	PHYSICAL THERAPY	385,376	117,618	502,994	0	502,994	66.00
67.00	06700	OCCUPATIONAL THERAPY	151,264	9,718	160,982	0	160,982	67.00
68.00	06800	SPEECH PATHOLOGY	26,636	40,860	67,496	0	67,496	68.00
69.00	06900	ELECTROCARDIOLOGY	31,844	102,630	134,474	0	134,474	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	35,362	77,519	112,881	208,446	321,327	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	385,574	2,119,400	2,504,974	123,480	2,628,454	73.00
75.00	07500	ASC (NON-DISTINCT PART)	162,582	25,584	188,166	0	188,166	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,571,218	257,729	1,828,947	-2,021	1,826,926	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	937,454	1,956,198	2,893,652	0	2,893,652	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,933	1,933	-475	1,458	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,399,981	1,399,981	-1,399,981	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,962,429	18,925,951	30,888,380	-2,195	30,886,185	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,274	13,274	0	13,274	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,724,854	394,035	3,118,889	2,767	3,121,656	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	96,746	96,746	0	96,746	194.01
194.02	07952	FOUNDATION	0	13,912	13,912	-572	13,340	194.02
200.00		TOTAL (SUM OF LINES 118-199)	14,687,283	19,443,918	34,131,201	0	34,131,201	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/27/2017 4:11 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	298,823	2,619,823		1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	0	10,180		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	321,734	2,146,514		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,688,036	5,201,663		4.00
5.01	01140	BUSINESS OFFICE	-74,116	499,415		5.01
5.02	00550	DATA PROCESSING	0	740,619		5.02
5.03	00570	ADMITTING	0	326,290		5.03
5.04	00560	PURCHASING RECEIVING AND STORES	0	114,441		5.04
5.05	00590	OTHER A&G	20,805	2,722,358		5.05
7.00	00700	OPERATION OF PLANT	0	943,907		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	69,083		8.00
9.00	00900	HOUSEKEEPING	0	392,333		9.00
10.00	01000	DIETARY	-9,198	115,781		10.00
11.00	01100	CAFETERIA	-85,591	215,833		11.00
13.00	01300	NURSING ADMINISTRATION	0	141,552		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-10,164	276,926		16.00
17.00	01700	SOCIAL SERVICE	0	116,979		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,725,865		30.00
31.00	03100	INTENSIVE CARE UNIT	0	263,650		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	759,061		50.00
51.00	05100	RECOVERY ROOM	0	85,308		51.00
53.00	05300	ANESTHESIOLOGY	-622,070	51,760		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	800,493		54.00
56.00	05600	RADIOISOTOPE	0	410,162		56.00
57.00	05700	CT SCAN	0	420,406		57.00
58.00	05800	MRI	0	154,507		58.00
60.00	06000	LABORATORY	-14,370	1,443,650		60.00
64.00	06400	INTRAVENOUS THERAPY	0	392,300		64.00
65.00	06500	RESPIRATORY THERAPY	0	513,286		65.00
66.00	06600	PHYSICAL THERAPY	0	502,994		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	160,982		67.00
68.00	06800	SPEECH PATHOLOGY	0	67,496		68.00
69.00	06900	ELECTROCARDIOLOGY	-89,463	45,011		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	321,327		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,628,454		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	188,166		75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,826,926		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-950,510	1,943,142		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	-1,458	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	472,458	31,358,643		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,274		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,121,656		192.00
194.00	07950	OTHER NRCC	0	0		194.00
194.01	07951	MARKETING	0	96,746		194.01
194.02	07952	FOUNDATION	0	13,340		194.02
200.00		TOTAL (SUM OF LINES 118-199)	472,458	34,603,659		200.00

RECLASSIFICATIONS | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/27/2017 4:11 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,368,367		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	31,614		2.00
	0		0	1,399,981		
	B - TO RECLASS COPIER LEASE EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,025		1.00
	0		0	3,025		
	C - TO RECLASS UTILITY EXPENSE					
1.00	OPERATION OF PLANT	7.00	0	475		1.00
	0		0	475		
	D - TO RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	208,107	93,317		1.00
	0		208,107	93,317		
	E - TO RECLASS OFFSITE CLINIC EXPENSE					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	9,104		1.00
	0		0	9,104		
	F - TO RECLASS BLDG DEPR EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	798,172		1.00
2.00	CAP REL COSTS-OFFSITE MOBS	1.01	0	8,764		2.00
	0		0	806,936		
	G - TO RECLASS PHY CLNC OFF EQPMT DPR					
1.00	CAP REL COSTS-OFFSITE MOBS	1.01	0	1,416		1.00
	0		0	1,416		
	H - TO RECLASS PROPERTY INS EXP					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	154,461		1.00
	0		0	154,461		
	I - TO RECLASS WORKERS COMP					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	73,999		1.00
	0		0	73,999		
	K - TO RECLASS IMPLANTS AND O2 EXP					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	214,235		1.00
2.00		0.00	0	0		2.00
	0		0	214,235		
	L - TO RECLASS DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	123,480		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
	0		0	123,480		
	O - TO RECLLASS NURSING ADMIN EXP					
1.00	NURSING ADMINISTRATION	13.00	140,189	1,363		1.00
	0		140,189	1,363		
	P - TO RECLASS ADVERTISING EXPENSE					
1.00	OTHER A&G	5.05	0	3,262		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
	0		0	3,262		
	V - TO RECLASS PHYSICIAN ADMIN COSTS					
1.00	OTHER A&G	5.05	4,754	0		1.00
2.00		0.00	0	0		2.00
	0		4,754	0		
	W - TO RECLASS RADIOLOGY EXPENSES					
1.00	RADIOISOTOPE	56.00	0	410,162		1.00
2.00	CT SCAN	57.00	146,686	273,720		2.00
3.00	MRI	58.00	78,008	76,007		3.00
	0		224,694	759,889		
	X - TELEPHONE EXPENSE					
1.00	DATA PROCESSING	5.02	0	2,931		1.00
	0		0	2,931		
500.00	Grand Total: Increases		577,744	3,647,874		500.00

RECLASSIFICATIONS | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/27/2017 4:11 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,399,981	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	1,399,981			
	B - TO RECLASS COPIER LEASE EXPENSE						
1.00	OTHER A&G	5.05	0	3,025	10		1.00
	0		0	3,025			
	C - TO RECLASS UTILITY EXPENSE						
1.00	HOME HEALTH AGENCY	101.00	0	475	0		1.00
	0		0	475			
	D - TO RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	208,107	93,317	0		1.00
	0		208,107	93,317			
	E - TO RECLASS OFFSITE CLINIC EXPENSE						
1.00	OTHER A&G	5.05	0	9,104	0		1.00
	0		0	9,104			
	F - TO RECLASS BLDG DEPR EXPENSE						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	806,936	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	806,936			
	G - TO RECLASS PHY CLNC OFF EQPMT DPR						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,416	9		1.00
	0		0	1,416			
	H - TO RECLASS PROPERTY INS EXP						
1.00	OTHER A&G	5.05	0	154,461	14		1.00
	0		0	154,461			
	I - TO RECLASS WORKERS COMP						
1.00	OTHER A&G	5.05	0	73,999	0		1.00
	0		0	73,999			
	K - TO RECLASS IMPLANTS AND O2 EXP						
1.00	OPERATING ROOM	50.00	0	206,050	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	8,185	0		2.00
	0		0	214,235			
	L - TO RECLASS DRUGS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	5,789	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	13,226	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	75,804	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	2,594	0		4.00
5.00	INTRAVENOUS THERAPY	64.00	0	26,067	0		5.00
	0		0	123,480			
	O - TO RECLLASS NURSING ADMIN EXP						
1.00	OTHER A&G	5.05	140,189	1,363	0		1.00
	0		140,189	1,363			
	P - TO RECLASS ADVERTISING EXPENSE						
1.00	RURAL HEALTH CLINIC	88.00	0	101	0		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,017	0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	572	0		3.00
4.00	FOUNDATION	194.02	0	572	0		4.00
	0		0	3,262			
	V - TO RECLASS PHYSICIAN ADMIN COSTS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	2,834	0	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	1,920	0	0		2.00
	0		4,754	0			
	W - TO RECLASS RADIOLOGY EXPENSES						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	224,694	759,889	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		224,694	759,889			
	X - TELEPHONE EXPENSE						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,931	0		1.00
	0		0	2,931			
500.00	Grand Total: Decreases		577,744	3,647,874			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part I Date/Time Prepared: 2/27/2017 4:11 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,927,000	660,054	0	660,054	660,054	1.00
2.00	Land Improvements	2,096,452	2,880,649	0	2,880,649	2,571,901	2.00
3.00	Buildings and Fixtures	16,169,729	13,396,737	0	13,396,737	12,234,167	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	3,591,095	800,640	0	800,640	11,359	5.00
6.00	Movable Equipment	11,344,468	912,000	0	912,000	1,102,998	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,128,744	18,650,080	0	18,650,080	16,580,479	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	35,128,744	18,650,080	0	18,650,080	16,580,479	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,927,000	0	1.00
2.00	Land Improvements	2,405,200	0	2.00
3.00	Buildings and Fixtures	17,332,299	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,380,376	0	5.00
6.00	Movable Equipment	11,153,470	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,198,345	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	37,198,345	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 2/27/2017 4:11 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	0	0	0	0	0	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	2,598,493	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,598,493	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	0	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,598,493	2.00
3.00	Total (sum of lines 1-2)	0	2,598,493	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 2/27/2017 4:11 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	21,664,500	0	21,664,500	0.582405	0	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	301,658	0	301,658	0.008109	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	15,232,187	0	15,232,187	0.409486	0	2.00
3.00	Total (sum of lines 1-2)	37,198,345	0	37,198,345	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	904,609	-58,016	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	10,180	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,112,175	3,025	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,026,964	-54,991	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,618,769	0	0	154,461	2,619,823	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	0	10,180	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	31,314	0	0	0	2,146,514	2.00
3.00	Total (sum of lines 1-2)	1,650,083	0	0	154,461	4,776,517	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/27/2017 4:11 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)	B	-12,967	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - CAP REL COSTS-OFFSITE MOBS (chapter 2)		0	CAP REL COSTS-OFFSITE MOBS	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-300	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-8,466	OTHER A&G	5.05	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-182	OTHER A&G	5.05	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-58,016	CAP REL COSTS-BLDG & FIXT	1.00	10	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)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,671,885			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	3,036,231			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-61,836	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-10,164	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,570	CAFETERIA	11.00	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 - CAP REL COSTS-OFFSITE MOBS		0	CAP REL COSTS-OFFSITE MOBS	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	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/27/2017 4:11 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	-210,006	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	DIETARY REVENUE	B	-9,198	DIETARY	10.00	0	33.00
33.01	MEALS ON WHEELS	B	-22,185	CAFETERIA	11.00	0	33.01
33.02	AMBULANCE SUPPLY REVENUE	B	-4,528	EMERGENCY	91.00	0	33.02
33.03	LAB QUALITY CN REVENUE	B	-11,835	OTHER A&G	5.05	0	33.03
33.04	MISCELLANEOUS INCOME	B	-25,188	OTHER A&G	5.05	0	33.04
33.05	CABLE TV EXPENSE	A	-1,991	OTHER A&G	5.05	0	33.05
33.06	ADVERTISING EXPENSE	A	-673	OTHER A&G	5.05	0	33.06
33.07	COMMUNITY HEALTH EXPENSE	A	-24,092	OTHER A&G	5.05	0	33.07
33.08	COMMUNITY HEALTH BENEFIT EXPENSE	A	-3,862	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	LOBBYING EXPENSE	A	-14,872	OTHER A&G	5.05	0	33.09
33.10	CNRA BENEFIT EXPENSE	A	-44,328	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	PROVIDER TAX IDPA EXPENSE	A	-312,824	OTHER A&G	5.05	0	33.11
33.12	MERGER EXPENSES	A	-950	OTHER A&G	5.05	0	33.12
33.13	HOME HEALTH ELIMINATION	A	-1,458	HOME HEALTH AGENCY	101.00	0	33.13
33.14	CENTRAL BILLING OFFICE SALARIES	A	-4,479	BUSINESS OFFICE	5.01	0	33.14
33.15	CENTRAL BILLING OFFICE EXPENSES	A	-69,637	BUSINESS OFFICE	5.01	0	33.15
33.16	CENTRAL BILLING OFFICE BENEFITS	A	-1,281	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.16
33.17	LEGAL EXPENSE ADJUSTMENT	B	25,000	OTHER A&G	5.05	0	33.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		472,458				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: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 2/27/2017 4:11 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	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL BLDG HO BLDG CAPITA	106,437	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	532,040	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	OSF SAINT ELIZABETH	2,973,799	1,236,292	3.00
3.01	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	263,369	0	3.01
3.02	5.05	OTHER A&G	NON CAPITAL EXPENSE	396,878	0	3.02
4.00	5.02	DATA PROCESSING	OSF SAINT ELIZABETH	22,451	22,451	4.00
4.01	5.04	PURCHASING RECEIVING AND STO	OSF SAINT ELIZABETH	11,468	11,468	4.01
4.02	5.05	OTHER A&G	OSF SAINT ELIZABETH	34,842	34,842	4.02
4.03	7.00	OPERATION OF PLANT	OSF SAINT ELIZABETH	17,707	17,707	4.03
4.04	9.00	HOUSEKEEPING	OSF SAINT ELIZABETH	18,056	18,056	4.04
4.05	54.00	RADIOLOGY-DIAGNOSTIC	OSF SAINT ELIZABETH	354	354	4.05
4.06	60.00	LABORATORY	OSF SAINT ELIZABETH	13,317	13,317	4.06
4.07	73.00	DRUGS CHARGED TO PATIENTS	OSF SAINT ELIZABETH	397	397	4.07
4.08	192.00	PHYSICIANS' PRIVATE OFFICES	OSF SAINT ELIZABETH	2,400	2,400	4.08
4.09	60.00	LABORATORY	OSF SAINT ANTHONY	2,770	2,770	4.09
4.10	73.00	DRUGS CHARGED TO PATIENTS	OSF SAINT ANTHONY	454	454	4.10
4.11	60.00	LABORATORY	OSF SAINT FRANCIS MEDICAL CE	157,898	157,898	4.11
4.12	91.00	EMERGENCY	OSF SAINT FRANCIS MEDICAL CE	250	250	4.12
4.13	4.00	EMPLOYEE BENEFITS DEPARTMENT	OSF SAINT FRANCIS, INC.	744	744	4.13
4.14	30.00	ADULTS & PEDIATRICS	OSF SAINT FRANCIS, INC.	3,984	3,984	4.14
4.15	192.00	PHYSICIANS' PRIVATE OFFICES	OSF SAINT FRANCIS, INC.	360,396	360,396	4.15
4.16	192.00	PHYSICIANS' PRIVATE OFFICES	OSF MULTISPECIALTY GROUP	3,369,636	3,369,636	4.16
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,289,647	5,253,416	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	B		0.00	OSF HEALTHCARE	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

(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: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 2/27/2017 4:11 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	106,437	9		1.00
2.00	532,040	9		2.00
3.00	1,737,507	0		3.00
3.01	263,369	11		3.01
3.02	396,878	0		3.02
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
5.00	3,036,231			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	HOME OFFICE		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: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 2/27/2017 4:11 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	60.00	LABORATORY	27,870	14,370	13,500	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	89,463	89,463	0	0	0	2.00
3.00	91.00	EMERGENCY	1,758,375	945,982	812,393	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	622,070	622,070	0	0	0	4.00
5.00	5.05	OTHER A&G	4,754	0	4,754	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			2,502,532	1,671,885	830,647		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	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	5.05	OTHER A&G	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	60.00	LABORATORY	0	0	0	14,370		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	89,463		2.00
3.00	91.00	EMERGENCY	0	0	0	945,982		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	622,070		4.00
5.00	5.05	OTHER A&G	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	1,671,885		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/27/2017 4:11 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					0	1.00
2.00	Line 1 multiplied by 15 hours per week					0	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					152	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					0.00	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	1,302.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	78.92	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)	39.46	39.46	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)					102,793	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)					102,793	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)					102,793	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)					102,793	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)					5,998	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)					5,998	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)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					5,998	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					5,998	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: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/27/2017 4:11 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)	78.92	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)	102,793		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	5,998		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)	108,791		63.00
64.00	Total cost of outside supplier services (from your records)	86,343		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	5,998		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	5,998		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	0		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	0		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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/27/2017 4:11 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					0	1.00
2.00	Line 1 multiplied by 15 hours per week					0	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					119	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					0.00	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	685.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	71.88	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)	35.94	35.94	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)					49,274	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)					49,274	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)					49,274	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)					49,274	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					4,277	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					4,277	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)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					4,277	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)					4,277	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: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/27/2017 4:11 pm

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	71.88	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)	49,274		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	4,277		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)	53,551		63.00
64.00	Total cost of outside supplier services (from your records)	39,501		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	4,277		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	4,277		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	0		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	0		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: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/27/2017 4:11 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP		
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,619,823	2,619,823				1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	10,180	0	10,180			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,146,514			2,146,514		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,201,663	3,696	0	3,028	5,208,387	4.00
5.01	01140	BUSINESS OFFICE	499,415	34,859	0	28,561	87,488	5.01
5.02	00550	DATA PROCESSING	740,619	102,872	0	84,287	74,611	5.02
5.03	00570	ADMITTING	326,290	21,492	0	17,609	99,497	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	114,441	9,540	0	7,817	35,508	5.04
5.05	00590	OTHER A&G	2,722,358	510,219	0	418,041	256,888	5.05
7.00	00700	OPERATION OF PLANT	943,907	117,497	0	96,270	111,818	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	69,083	12,423	0	10,179	0	8.00
9.00	00900	HOUSEKEEPING	392,333	28,673	0	23,493	125,263	9.00
10.00	01000	DIETARY	115,781	71,316	0	58,432	31,422	10.00
11.00	01100	CAFETERIA	215,833	28,149	0	23,063	75,784	11.00
13.00	01300	NURSING ADMINISTRATION	141,552	9,304	0	7,623	51,051	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	276,926	23,248	0	19,048	83,259	16.00
17.00	01700	SOCIAL SERVICE	116,979	7,837	0	6,421	42,055	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,725,865	400,403	0	328,064	552,692	30.00
31.00	03100	INTENSIVE CARE UNIT	263,650	60,649	0	49,692	76,745	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	759,061	114,562	0	93,864	154,898	50.00
51.00	05100	RECOVERY ROOM	85,308	20,260	0	16,600	18,392	51.00
53.00	05300	ANESTHESIOLOGY	51,760	3,381	0	2,770	227,848	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	800,493	100,225	0	82,118	150,997	54.00
56.00	05600	RADIOISOTOPE	410,162	18,006	0	14,753	0	56.00
57.00	05700	CT SCAN	420,406	12,135	0	9,943	53,417	57.00
58.00	05800	MRI	154,507	27,179	0	22,269	28,407	58.00
60.00	06000	LABORATORY	1,443,650	49,746	0	40,758	238,557	60.00
64.00	06400	INTRAVENOUS THERAPY	392,300	117,733	0	96,463	128,164	64.00
65.00	06500	RESPIRATORY THERAPY	513,286	56,744	0	46,492	170,302	65.00
66.00	06600	PHYSICAL THERAPY	502,994	56,901	0	46,621	140,339	66.00
67.00	06700	OCCUPATIONAL THERAPY	160,982	10,851	0	8,890	55,084	67.00
68.00	06800	SPEECH PATHOLOGY	67,496	2,647	0	2,169	9,700	68.00
69.00	06900	ELECTROCARDIOLOGY	45,011	2,673	0	2,190	11,596	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	321,327	73,308	0	60,064	12,877	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,628,454	20,732	0	16,986	140,411	73.00
75.00	07500	ASC (NON-DISTINCT PART)	188,166	108,271	0	88,711	59,206	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,826,926	155,711	0	127,579	571,477	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,943,142	129,685	0	106,255	341,384	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,358,643	2,522,927	0	2,067,123	4,217,137	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,274	6,343	0	5,197	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,121,656	87,487	10,180	71,681	991,250	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	96,746	1,546	0	1,267	0	194.01
194.02	07952	FOUNDATION	13,340	1,520	0	1,246	0	194.02
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)	34,603,659	2,619,823	10,180	2,146,514	5,208,387	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/27/2017 4:11 pm

		Cost Center Description	Subtotal	BUSINESS OFFICE	DATA PROCESSING	Subtotal	ADMITTING	
			4A	5.01	5.02	5A.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE	650,323	650,323				5.01
5.02	00550	DATA PROCESSING	1,002,389	19,279	1,021,668			5.02
5.03	00570	ADMITTING	464,888	8,941	11,547	485,376	485,376	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	167,306	3,218	13,380	183,904	3,329	5.04
5.05	00590	OTHER A&G	3,907,506	75,153	79,178	4,061,837	73,542	5.05
7.00	00700	OPERATION OF PLANT	1,269,492	24,416	269,720	1,563,628	28,308	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	91,685	1,763	0	93,448	1,692	8.00
9.00	00900	HOUSEKEEPING	569,762	10,958	231,134	811,854	14,698	9.00
10.00	01000	DIETARY	276,951	5,327	6,606	288,884	5,230	10.00
11.00	01100	CAFETERIA	342,829	6,594	15,938	365,361	6,614	11.00
13.00	01300	NURSING ADMINISTRATION	209,530	4,030	0	213,560	3,866	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	402,481	7,741	806	411,028	7,441	16.00
17.00	01700	SOCIAL SERVICE	173,292	3,333	0	176,625	3,198	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,007,024	57,834	56,304	3,121,162	56,506	30.00
31.00	03100	INTENSIVE CARE UNIT	450,736	8,669	3,482	462,887	8,380	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,122,385	21,587	23,900	1,167,872	21,143	50.00
51.00	05100	RECOVERY ROOM	140,560	2,703	0	143,263	2,594	51.00
53.00	05300	ANESTHESIOLOGY	285,759	5,496	0	291,255	5,273	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,133,833	21,807	24,956	1,180,596	21,374	54.00
56.00	05600	RADIOISOTOPE	442,921	8,519	4,479	455,919	8,254	56.00
57.00	05700	CT SCAN	495,901	9,538	3,020	508,459	9,205	57.00
58.00	05800	MRI	232,362	4,469	6,767	243,598	4,410	58.00
60.00	06000	LABORATORY	1,772,711	34,095	87,902	1,894,708	34,302	60.00
64.00	06400	INTRAVENOUS THERAPY	734,660	14,130	0	748,790	13,556	64.00
65.00	06500	RESPIRATORY THERAPY	786,824	15,133	11,327	813,284	14,724	65.00
66.00	06600	PHYSICAL THERAPY	746,855	14,364	25,440	786,659	14,242	66.00
67.00	06700	OCCUPATIONAL THERAPY	235,807	4,535	26,869	267,211	4,838	67.00
68.00	06800	SPEECH PATHOLOGY	82,012	1,577	0	83,589	1,513	68.00
69.00	06900	ELECTROCARDIOLOGY	61,470	1,182	4,509	67,161	1,216	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	467,576	8,993	440	477,009	8,636	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,806,583	53,979	9,127	2,869,689	51,953	73.00
75.00	07500	ASC (NON-DISTINCT PART)	444,354	8,546	15,909	468,809	8,487	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,681,693	51,577	17,119	2,750,389	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,520,466	48,476	18,988	2,587,930	46,852	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,180,926	567,962	968,847	30,045,744	485,376	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	24,814	0	0	24,814	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,282,254	82,361	33,467	4,398,082	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	99,559	0	9,677	109,236	0	194.01
194.02	07952	FOUNDATION	16,106	0	9,677	25,783	0	194.02
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)	34,603,659	650,323	1,021,668	34,603,659	485,376	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/27/2017 4:11 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES	Subtotal	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.04	5A.04	5.05	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES	187,233					5.04
5.05	00590	OTHER A&G	5,071	4,140,450	4,140,450			5.05
7.00	00700	OPERATION OF PLANT	3,495	1,595,431	216,845	1,812,276		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	95,140	12,931	12,373	120,444	8.00
9.00	00900	HOUSEKEEPING	3,388	829,940	112,802	28,557	0	9.00
10.00	01000	DIETARY	844	294,958	40,090	71,027	0	10.00
11.00	01100	CAFETERIA	586	372,561	50,637	28,035	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	217,426	29,552	9,267	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	190	418,659	56,902	23,154	0	16.00
17.00	01700	SOCIAL SERVICE	21	179,844	24,444	7,805	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,971	3,193,639	434,067	398,780	30,083	30.00
31.00	03100	INTENSIVE CARE UNIT	924	472,191	64,178	60,403	2,990	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,400	1,220,415	165,874	114,098	14,031	50.00
51.00	05100	RECOVERY ROOM	0	145,857	19,824	20,178	0	51.00
53.00	05300	ANESTHESIOLOGY	5,332	301,860	41,028	3,367	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,858	1,203,828	163,619	99,819	9,166	54.00
56.00	05600	RADIOISOTOPE	334	464,507	63,134	17,933	1,647	56.00
57.00	05700	CT SCAN	225	517,889	70,389	12,086	1,110	57.00
58.00	05800	MRI	504	248,512	33,777	27,069	2,486	58.00
60.00	06000	LABORATORY	65,382	1,994,392	271,070	49,544	0	60.00
64.00	06400	INTRAVENOUS THERAPY	4,934	767,280	104,286	117,256	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,082	831,090	112,958	56,514	1,414	65.00
66.00	06600	PHYSICAL THERAPY	3,420	804,321	109,320	56,670	11,202	66.00
67.00	06700	OCCUPATIONAL THERAPY	882	272,931	37,096	10,807	2,906	67.00
68.00	06800	SPEECH PATHOLOGY	68	85,170	11,576	2,636	0	68.00
69.00	06900	ELECTROCARDIOLOGY	725	69,102	9,392	2,663	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	485,645	66,007	73,011	62	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,780	2,923,422	397,340	20,648	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	3,873	481,169	65,399	107,833	6,163	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,318	2,759,707	375,088	155,080	796	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	14,410	2,649,192	360,068	129,159	35,171	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	178,017	30,036,528	3,519,693	1,715,772	119,227	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,814	3,373	6,317	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,871	4,406,953	598,986	87,133	1,217	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	345	109,581	14,894	1,540	0	194.01
194.02	07952	FOUNDATION	0	25,783	3,504	1,514	0	194.02
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	187,233	34,603,659	4,140,450	1,812,276	120,444	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/27/2017 4:11 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	971,299					9.00
10.00	01000	DIETARY	9,532	415,607				10.00
11.00	01100	CAFETERIA	22,730	0	473,963			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	15,799	272,044		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,777	0	18,959	0	527,451	16.00
17.00	01700	SOCIAL SERVICE	0	0	6,320	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	257,124	375,617	94,789	121,935	138,615	30.00
31.00	03100	INTENSIVE CARE UNIT	21,753	21,135	9,479	12,096	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	51,082	0	22,118	28,230	0	50.00
51.00	05100	RECOVERY ROOM	9,043	0	3,160	3,111	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	6,320	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,838	0	25,278	0	61,663	54.00
56.00	05600	RADIOISOTOPE	9,043	0	0	0	11,212	56.00
57.00	05700	CT SCAN	6,110	0	3,160	0	7,644	57.00
58.00	05800	MRI	13,687	0	3,160	0	16,817	58.00
60.00	06000	LABORATORY	33,973	0	41,077	0	6,625	60.00
64.00	06400	INTRAVENOUS THERAPY	32,507	0	18,959	25,203	0	64.00
65.00	06500	RESPIRATORY THERAPY	23,464	0	28,438	0	11,212	65.00
66.00	06600	PHYSICAL THERAPY	21,508	0	18,959	0	4,587	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,622	0	6,320	0	510	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	510	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	3,160	1,998	1,529	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,133	0	6,320	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,021	0	9,479	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	48,394	2,362	9,479	12,993	28,538	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	121,962	4,276	0	0	77,461	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	89,211	12,217	50,556	65,908	87,144	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	852,514	415,607	401,289	271,474	454,067	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	118,785	0	72,674	570	73,384	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
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)	971,299	415,607	473,963	272,044	527,451	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/27/2017 4:11 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	218,413					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	201,255	5,245,904	0	5,245,904		30.00
31.00	03100	INTENSIVE CARE UNIT	7,864	672,089	0	672,089		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,615,848	0	1,615,848		50.00
51.00	05100	RECOVERY ROOM	0	201,173	0	201,173		51.00
53.00	05300	ANESTHESIOLOGY	0	352,575	0	352,575		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,614,211	0	1,614,211		54.00
56.00	05600	RADIOISOTOPE	0	567,476	0	567,476		56.00
57.00	05700	CT SCAN	0	618,388	0	618,388		57.00
58.00	05800	MRI	0	345,508	0	345,508		58.00
60.00	06000	LABORATORY	0	2,396,681	0	2,396,681		60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,065,491	0	1,065,491		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,065,090	0	1,065,090		65.00
66.00	06600	PHYSICAL THERAPY	0	1,026,567	0	1,026,567		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	336,192	0	336,192		67.00
68.00	06800	SPEECH PATHOLOGY	0	99,892	0	99,892		68.00
69.00	06900	ELECTROCARDIOLOGY	0	87,844	0	87,844		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	636,178	0	636,178		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,360,910	0	3,360,910		73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,860	765,190	0	765,190		75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,494,370	0	3,494,370		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	6,434	3,485,060	0	3,485,060		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	218,413	29,052,637	0	29,052,637		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34,504	0	34,504		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,359,702	0	5,359,702		192.00
194.00	07950	OTHER NRCC	0	0	0	0		194.00
194.01	07951	MARKETING	0	126,015	0	126,015		194.01
194.02	07952	FOUNDATION	0	30,801	0	30,801		194.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	218,413	34,603,659	0	34,603,659		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/27/2017 4:11 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS OFFSITE MOBS	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	
			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	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,696	0	3,028	6,724	4.00
5.01	01140	BUSINESS OFFICE	0	34,859	0	28,561	63,420	5.01
5.02	00550	DATA PROCESSING	0	102,872	0	84,287	187,159	5.02
5.03	00570	ADMITTING	0	21,492	0	17,609	39,101	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	0	9,540	0	7,817	17,357	5.04
5.05	00590	OTHER A&G	3,025	510,219	0	418,041	931,285	5.05
7.00	00700	OPERATION OF PLANT	0	117,497	0	96,270	213,767	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,423	0	10,179	22,602	8.00
9.00	00900	HOUSEKEEPING	0	28,673	0	23,493	52,166	9.00
10.00	01000	DIETARY	0	71,316	0	58,432	129,748	10.00
11.00	01100	CAFETERIA	0	28,149	0	23,063	51,212	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,304	0	7,623	16,927	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,248	0	19,048	42,296	16.00
17.00	01700	SOCIAL SERVICE	0	7,837	0	6,421	14,258	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	400,403	0	328,064	728,467	30.00
31.00	03100	INTENSIVE CARE UNIT	0	60,649	0	49,692	110,341	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	114,562	0	93,864	208,426	50.00
51.00	05100	RECOVERY ROOM	0	20,260	0	16,600	36,860	51.00
53.00	05300	ANESTHESIOLOGY	0	3,381	0	2,770	6,151	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	100,225	0	82,118	182,343	54.00
56.00	05600	RADIOISOTOPE	0	18,006	0	14,753	32,759	56.00
57.00	05700	CT SCAN	0	12,135	0	9,943	22,078	57.00
58.00	05800	MRI	0	27,179	0	22,269	49,448	58.00
60.00	06000	LABORATORY	0	49,746	0	40,758	90,504	60.00
64.00	06400	INTRAVENOUS THERAPY	0	117,733	0	96,463	214,196	64.00
65.00	06500	RESPIRATORY THERAPY	0	56,744	0	46,492	103,236	65.00
66.00	06600	PHYSICAL THERAPY	0	56,901	0	46,621	103,522	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,851	0	8,890	19,741	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,647	0	2,169	4,816	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,673	0	2,190	4,863	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	73,308	0	60,064	133,372	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,732	0	16,986	37,718	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	108,271	0	88,711	196,982	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	155,711	0	127,579	283,290	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	129,685	0	106,255	235,940	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,025	2,522,927	0	2,067,123	4,593,075	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,343	0	5,197	11,540	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,606	87,487	10,180	71,681	185,954	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,546	0	1,267	2,813	194.01
194.02	07952	FOUNDATION	0	1,520	0	1,246	2,766	194.02
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)	19,631	2,619,823	10,180	2,146,514	4,796,148	202.00

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		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	BUSINESS OFFICE	DATA PROCESSING	ADMITTING	PURCHASING RECEIVING AND STORES	
			4.00	5.01	5.02	5.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,724					4.00
5.01	01140	BUSINESS OFFICE	113	63,533				5.01
5.02	00550	DATA PROCESSING	96	1,883	189,138			5.02
5.03	00570	ADMITTING	128	874	2,138	42,241		5.03
5.04	00560	PURCHASING RECEIVING AND STORES	46	314	2,477	290	20,484	5.04
5.05	00590	OTHER A&G	332	7,342	14,658	6,387	555	5.05
7.00	00700	OPERATION OF PLANT	144	2,385	49,930	2,464	382	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	172	0	147	0	8.00
9.00	00900	HOUSEKEEPING	162	1,071	42,789	1,279	371	9.00
10.00	01000	DIETARY	41	520	1,223	455	92	10.00
11.00	01100	CAFETERIA	98	644	2,951	576	64	11.00
13.00	01300	NURSING ADMINISTRATION	66	394	0	337	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	107	756	149	648	21	16.00
17.00	01700	SOCIAL SERVICE	54	326	0	278	2	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	713	5,650	10,423	4,919	1,747	30.00
31.00	03100	INTENSIVE CARE UNIT	99	847	645	730	101	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	200	2,109	4,425	1,841	3,435	50.00
51.00	05100	RECOVERY ROOM	24	264	0	226	0	51.00
53.00	05300	ANESTHESIOLOGY	294	537	0	459	583	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	195	2,130	4,620	1,861	203	54.00
56.00	05600	RADIOISOTOPE	0	832	829	719	37	56.00
57.00	05700	CT SCAN	69	932	559	801	25	57.00
58.00	05800	MRI	37	437	1,253	384	55	58.00
60.00	06000	LABORATORY	308	3,331	16,273	2,986	7,153	60.00
64.00	06400	INTRAVENOUS THERAPY	165	1,380	0	1,180	540	64.00
65.00	06500	RESPIRATORY THERAPY	220	1,478	2,097	1,282	337	65.00
66.00	06600	PHYSICAL THERAPY	181	1,403	4,710	1,240	374	66.00
67.00	06700	OCCUPATIONAL THERAPY	71	443	4,974	421	97	67.00
68.00	06800	SPEECH PATHOLOGY	13	154	0	132	7	68.00
69.00	06900	ELECTROCARDIOLOGY	15	116	835	106	79	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17	879	81	752	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	181	5,274	1,690	4,523	195	73.00
75.00	07500	ASC (NON-DISTINCT PART)	76	835	2,945	739	424	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	738	5,039	3,169	0	1,019	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	441	4,736	3,515	4,079	1,577	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,444	55,487	179,358	42,241	19,475	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	1,280	8,046	6,196	0	971	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	1,792	0	38	194.01
194.02	07952	FOUNDATION	0	0	1,792	0	0	194.02
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)	6,724	63,533	189,138	42,241	20,484	202.00

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		Cost Center Description	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.05	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	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G	960,559					5.05
7.00	00700	OPERATION OF PLANT	50,307	319,379				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,000	2,181	28,102			8.00
9.00	00900	HOUSEKEEPING	26,170	5,033	0	129,041		9.00
10.00	01000	DIETARY	9,301	12,517	0	1,266	155,163	10.00
11.00	01100	CAFETERIA	11,748	4,941	0	3,020	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,856	1,633	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,201	4,080	0	1,299	0	16.00
17.00	01700	SOCIAL SERVICE	5,671	1,375	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	100,702	70,279	7,019	34,161	140,234	30.00
31.00	03100	INTENSIVE CARE UNIT	14,889	10,645	698	2,890	7,890	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	38,482	20,108	3,274	6,787	0	50.00
51.00	05100	RECOVERY ROOM	4,599	3,556	0	1,201	0	51.00
53.00	05300	ANESTHESIOLOGY	9,518	593	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,959	17,591	2,139	6,754	0	54.00
56.00	05600	RADIOISOTOPE	14,647	3,160	384	1,201	0	56.00
57.00	05700	CT SCAN	16,330	2,130	259	812	0	57.00
58.00	05800	MRI	7,836	4,770	580	1,818	0	58.00
60.00	06000	LABORATORY	62,887	8,731	0	4,514	0	60.00
64.00	06400	INTRAVENOUS THERAPY	24,194	20,664	0	4,319	0	64.00
65.00	06500	RESPIRATORY THERAPY	26,206	9,959	330	3,117	0	65.00
66.00	06600	PHYSICAL THERAPY	25,362	9,987	2,614	2,857	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,606	1,904	678	747	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,686	465	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,179	469	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,313	12,867	15	682	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	92,181	3,639	0	1,331	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	15,172	19,003	1,438	6,429	882	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	87,019	27,330	186	16,203	1,596	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	83,534	22,762	8,204	11,852	4,561	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	816,555	302,372	27,818	113,260	155,163	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	782	1,113	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	138,954	15,356	284	15,781	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	3,455	271	0	0	0	194.01
194.02	07952	FOUNDATION	813	267	0	0	0	194.02
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)	960,559	319,379	28,102	129,041	155,163	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/27/2017 4:11 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			11.00	13.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
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	75,254					11.00
13.00	01300	NURSING ADMINISTRATION	2,508	28,721				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,010	0	65,567			16.00
17.00	01700	SOCIAL SERVICE	1,003	0	0	22,967		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,052	12,874	17,231	21,162	1,170,633	30.00
31.00	03100	INTENSIVE CARE UNIT	1,505	1,277	0	827	153,384	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,512	2,980	0	0	295,579	50.00
51.00	05100	RECOVERY ROOM	502	328	0	0	47,560	51.00
53.00	05300	ANESTHESIOLOGY	1,003	0	0	0	19,138	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,014	0	7,665	0	267,474	54.00
56.00	05600	RADIOISOTOPE	0	0	1,394	0	55,962	56.00
57.00	05700	CT SCAN	502	0	950	0	45,447	57.00
58.00	05800	MRI	502	0	2,091	0	69,211	58.00
60.00	06000	LABORATORY	6,522	0	824	0	204,033	60.00
64.00	06400	INTRAVENOUS THERAPY	3,010	2,661	0	0	272,309	64.00
65.00	06500	RESPIRATORY THERAPY	4,515	0	1,394	0	154,171	65.00
66.00	06600	PHYSICAL THERAPY	3,010	0	570	0	155,830	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,003	0	63	0	38,748	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	63	0	8,336	68.00
69.00	06900	ELECTROCARDIOLOGY	502	211	190	0	9,565	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,003	0	0	0	164,981	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,505	0	0	0	148,237	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,505	1,372	3,548	301	251,651	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	9,629	0	435,218	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,027	6,958	10,833	677	407,696	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	63,715	28,661	56,445	22,967	4,375,163	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	13,435	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,539	60	9,122	0	393,543	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	8,369	194.01
194.02	07952	FOUNDATION	0	0	0	0	5,638	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	75,254	28,721	65,567	22,967	4,796,148	202.00

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		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	01140	BUSINESS OFFICE				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00570	ADMITTING				5.03
5.04	00560	PURCHASING RECEIVING AND STORES				5.04
5.05	00590	OTHER A&G				5.05
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
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,170,633		30.00
31.00	03100	INTENSIVE CARE UNIT	0	153,384		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	295,579		50.00
51.00	05100	RECOVERY ROOM	0	47,560		51.00
53.00	05300	ANESTHESIOLOGY	0	19,138		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	267,474		54.00
56.00	05600	RADIOISOTOPE	0	55,962		56.00
57.00	05700	CT SCAN	0	45,447		57.00
58.00	05800	MRI	0	69,211		58.00
60.00	06000	LABORATORY	0	204,033		60.00
64.00	06400	INTRAVENOUS THERAPY	0	272,309		64.00
65.00	06500	RESPIRATORY THERAPY	0	154,171		65.00
66.00	06600	PHYSICAL THERAPY	0	155,830		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	38,748		67.00
68.00	06800	SPEECH PATHOLOGY	0	8,336		68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,565		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	164,981		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	148,237		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	251,651		75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	435,218		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	407,696		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,375,163		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,435		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	393,543		192.00
194.00	07950	OTHER NRCC	0	0		194.00
194.01	07951	MARKETING	0	8,369		194.01
194.02	07952	FOUNDATION	0	5,638		194.02
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	4,796,148		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 4:11 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	OFFSITE MOBS (MOB SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	99,957					1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	0	100				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			99,957			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	141	0	141	14,302,443		4.00
5.01	01140	BUSINESS OFFICE	1,330	0	1,330	240,246	-650,323	5.01
5.02	00550	DATA PROCESSING	3,925	0	3,925	204,886	0	5.02
5.03	00570	ADMITTING	820	0	820	273,222	0	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	364	0	364	97,505	0	5.04
5.05	00590	OTHER A&G	19,467	0	19,467	705,423	0	5.05
7.00	00700	OPERATION OF PLANT	4,483	0	4,483	307,056	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	474	0	474	0	0	8.00
9.00	00900	HOUSEKEEPING	1,094	0	1,094	343,977	0	9.00
10.00	01000	DIETARY	2,721	0	2,721	86,287	0	10.00
11.00	01100	CAFETERIA	1,074	0	1,074	208,107	0	11.00
13.00	01300	NURSING ADMINISTRATION	355	0	355	140,189	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	887	0	887	228,632	0	16.00
17.00	01700	SOCIAL SERVICE	299	0	299	115,486	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,277	0	15,277	1,517,712	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,314	0	2,314	210,744	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,371	0	4,371	425,356	0	50.00
51.00	05100	RECOVERY ROOM	773	0	773	50,504	0	51.00
53.00	05300	ANESTHESIOLOGY	129	0	129	625,680	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,824	0	3,824	414,643	0	54.00
56.00	05600	RADIOISOTOPE	687	0	687	0	0	56.00
57.00	05700	CT SCAN	463	0	463	146,686	0	57.00
58.00	05800	MRI	1,037	0	1,037	78,008	0	58.00
60.00	06000	LABORATORY	1,898	0	1,898	655,086	0	60.00
64.00	06400	INTRAVENOUS THERAPY	4,492	0	4,492	351,943	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,165	0	2,165	467,655	0	65.00
66.00	06600	PHYSICAL THERAPY	2,171	0	2,171	385,376	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	414	0	414	151,264	0	67.00
68.00	06800	SPEECH PATHOLOGY	101	0	101	26,636	0	68.00
69.00	06900	ELECTROCARDIOLOGY	102	0	102	31,844	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,797	0	2,797	35,362	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	791	0	791	385,574	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,131	0	4,131	162,582	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,941	0	5,941	1,569,298	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,948	0	4,948	937,454	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	96,260	0	96,260	11,580,423	-650,323	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	242	0	242	0	-24,814	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,338	100	3,338	2,722,020	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	59	0	59	0	-99,559	194.01
194.02	07952	FOUNDATION	58	0	58	0	-16,106	194.02
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)	2,619,823	10,180	2,146,514	5,208,387		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.209500	101.800000	21.474374	0.364161		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				6,724		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000470		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 4:11 pm

		Cost Center Description	BUSINESS OFFICE (ACCUM. COST)	DATA PROCESSING (MACHINE HOURS)	Reconciliation	ADMITTING (ACCUM. COST)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
			5.01	5.02	5A.03	5.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE	33,812,857					5.01
5.02	00550	DATA PROCESSING	1,002,389	139,357				5.02
5.03	00570	ADMITTING	464,888	1,575	-485,376	26,809,979		5.03
5.04	00560	PURCHASING RECEIVING AND STORES	167,306	1,825	0	183,904	1,179,211	5.04
5.05	00590	OTHER A&G	3,907,506	10,800	0	4,061,837	31,939	5.05
7.00	00700	OPERATION OF PLANT	1,269,492	36,790	0	1,563,628	22,015	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	91,685	0	0	93,448	0	8.00
9.00	00900	HOUSEKEEPING	569,762	31,527	0	811,854	21,336	9.00
10.00	01000	DIETARY	276,951	901	0	288,884	5,315	10.00
11.00	01100	CAFETERIA	342,829	2,174	0	365,361	3,693	11.00
13.00	01300	NURSING ADMINISTRATION	209,530	0	0	213,560	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	402,481	110	0	411,028	1,194	16.00
17.00	01700	SOCIAL SERVICE	173,292	0	0	176,625	131	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,007,024	7,680	0	3,121,162	100,588	30.00
31.00	03100	INTENSIVE CARE UNIT	450,736	475	0	462,887	5,817	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,122,385	3,260	0	1,167,872	197,759	50.00
51.00	05100	RECOVERY ROOM	140,560	0	0	143,263	0	51.00
53.00	05300	ANESTHESIOLOGY	285,759	0	0	291,255	33,581	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,133,833	3,404	0	1,180,596	11,705	54.00
56.00	05600	RADIOISOTOPE	442,921	611	0	455,919	2,103	56.00
57.00	05700	CT SCAN	495,901	412	0	508,459	1,417	57.00
58.00	05800	MRI	232,362	923	0	243,598	3,174	58.00
60.00	06000	LABORATORY	1,772,711	11,990	0	1,894,708	411,782	60.00
64.00	06400	INTRAVENOUS THERAPY	734,660	0	0	748,790	31,076	64.00
65.00	06500	RESPIRATORY THERAPY	786,824	1,545	0	813,284	19,412	65.00
66.00	06600	PHYSICAL THERAPY	746,855	3,470	0	786,659	21,538	66.00
67.00	06700	OCCUPATIONAL THERAPY	235,807	3,665	0	267,211	5,558	67.00
68.00	06800	SPEECH PATHOLOGY	82,012	0	0	83,589	426	68.00
69.00	06900	ELECTROCARDIOLOGY	61,470	615	0	67,161	4,568	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	467,576	60	0	477,009	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,806,583	1,245	0	2,869,689	11,208	73.00
75.00	07500	ASC (NON-DISTINCT PART)	444,354	2,170	0	468,809	24,392	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,681,693	2,335	-2,750,389	0	58,688	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,520,466	2,590	0	2,587,930	90,755	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,530,603	132,152	-3,235,765	26,809,979	1,121,170	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	-24,814	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,282,254	4,565	-4,398,082	0	55,869	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,320	-109,236	0	2,172	194.01
194.02	07952	FOUNDATION	0	1,320	-25,783	0	0	194.02
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)	650,323	1,021,668		485,376	187,233	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.019233	7.331300		0.018104	0.158778	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	63,533	189,138		42,241	20,484	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001879	1.357219		0.001576	0.017371	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 4:11 pm

		Cost Center Description	Reconciliation	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5A.05	5.05	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G	-4,140,450	30,463,209				5.05
7.00	00700	OPERATION OF PLANT	0	1,595,431	69,427			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	95,140	474	108,384		8.00
9.00	00900	HOUSEKEEPING	0	829,940	1,094	0	3,974	9.00
10.00	01000	DIETARY	0	294,958	2,721	0	39	10.00
11.00	01100	CAFETERIA	0	372,561	1,074	0	93	11.00
13.00	01300	NURSING ADMINISTRATION	0	217,426	355	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	418,659	887	0	40	16.00
17.00	01700	SOCIAL SERVICE	0	179,844	299	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,193,639	15,277	27,071	1,052	30.00
31.00	03100	INTENSIVE CARE UNIT	0	472,191	2,314	2,691	89	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,220,415	4,371	12,626	209	50.00
51.00	05100	RECOVERY ROOM	0	145,857	773	0	37	51.00
53.00	05300	ANESTHESIOLOGY	0	301,860	129	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,203,828	3,824	8,248	208	54.00
56.00	05600	RADIOISOTOPE	0	464,507	687	1,482	37	56.00
57.00	05700	CT SCAN	0	517,889	463	999	25	57.00
58.00	05800	MRI	0	248,512	1,037	2,237	56	58.00
60.00	06000	LABORATORY	0	1,994,392	1,898	0	139	60.00
64.00	06400	INTRAVENOUS THERAPY	0	767,280	4,492	0	133	64.00
65.00	06500	RESPIRATORY THERAPY	0	831,090	2,165	1,272	96	65.00
66.00	06600	PHYSICAL THERAPY	0	804,321	2,171	10,080	88	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	272,931	414	2,615	23	67.00
68.00	06800	SPEECH PATHOLOGY	0	85,170	101	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69,102	102	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	485,645	2,797	56	21	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,923,422	791	0	41	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	481,169	4,131	5,546	198	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,759,707	5,941	716	499	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,649,192	4,948	31,650	365	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,140,450	25,896,078	65,730	107,289	3,488	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,814	242	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,406,953	3,338	1,095	486	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	109,581	59	0	0	194.01
194.02	07952	FOUNDATION	0	25,783	58	0	0	194.02
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)		4,140,450	1,812,276	120,444	971,299	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.135916	26.103332	1.111271	244.413437	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		960,559	319,379	28,102	129,041	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.031532	4.600213	0.259282	32.471314	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 4:11 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
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	10,206					10.00
11.00	01100	CAFETERIA	0	150				11.00
13.00	01300	NURSING ADMINISTRATION	0	5	140,679			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6	0	1,035		16.00
17.00	01700	SOCIAL SERVICE	0	2	0	0	611	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,224	30	63,055	272	563	30.00
31.00	03100	INTENSIVE CARE UNIT	519	3	6,255	0	22	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7	14,598	0	0	50.00
51.00	05100	RECOVERY ROOM	0	1	1,609	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	2	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8	0	121	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	22	0	56.00
57.00	05700	CT SCAN	0	1	0	15	0	57.00
58.00	05800	MRI	0	1	0	33	0	58.00
60.00	06000	LABORATORY	0	13	0	13	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	6	13,033	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	9	0	22	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6	0	9	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2	0	1	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1	1,033	3	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	58	3	6,719	56	8	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	105	0	0	152	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	300	16	34,082	171	18	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,206	127	140,384	891	611	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	23	295	144	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
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)	415,607	473,963	272,044	527,451	218,413	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	40.721830	3,159.753333	1.933793	509.614493	357.468085	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	155,163	75,254	28,721	65,567	22,967	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	15.203116	501.693333	0.204160	63.349758	37.589198	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 4:11 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,245,904		5,245,904	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	672,089		672,089	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,615,848		1,615,848	0	0	50.00
51.00	05100	RECOVERY ROOM	201,173		201,173	0	0	51.00
53.00	05300	ANESTHESIOLOGY	352,575		352,575	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,614,211		1,614,211	0	0	54.00
56.00	05600	RADIOISOTOPE	567,476		567,476	0	0	56.00
57.00	05700	CT SCAN	618,388		618,388	0	0	57.00
58.00	05800	MRI	345,508		345,508	0	0	58.00
60.00	06000	LABORATORY	2,396,681		2,396,681	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,065,491		1,065,491	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,065,090	0	1,065,090	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,026,567	0	1,026,567	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	336,192	0	336,192	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	99,892	0	99,892	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	87,844		87,844	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	636,178		636,178	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,360,910		3,360,910	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	765,190		765,190	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,494,370		3,494,370	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,485,060		3,485,060	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,337,903		1,337,903		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	30,390,540	0	30,390,540	0	0	200.00
201.00		Less Observation Beds	1,337,903		1,337,903		0	201.00
202.00		Total (see instructions)	29,052,637	0	29,052,637	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 4:11 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	2,783,524		2,783,524			30.00
31.00	03100	INTENSIVE CARE UNIT	214,422		214,422			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	744,283	3,526,867	4,271,150	0.378317	0.000000	50.00
51.00	05100	RECOVERY ROOM	87,780	425,249	513,029	0.392128	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	199,915	1,075,471	1,275,386	0.276446	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	340,049	5,568,613	5,908,662	0.273194	0.000000	54.00
56.00	05600	RADIOISOTOPE	46,625	1,607,219	1,653,844	0.343125	0.000000	56.00
57.00	05700	CT SCAN	243,182	8,715,952	8,959,134	0.069023	0.000000	57.00
58.00	05800	MRI	142,082	2,745,084	2,887,166	0.119670	0.000000	58.00
60.00	06000	LABORATORY	855,667	10,300,358	11,156,025	0.214833	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	3,112	772,915	776,027	1.373008	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	462,650	567,863	1,030,513	1.033553	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	328,780	2,420,910	2,749,690	0.373339	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	106,408	605,079	711,487	0.472520	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	5,303	196,701	202,004	0.494505	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	26,292	1,878,868	1,905,160	0.046108	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,263,750	839,312	2,103,062	0.302501	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,601,012	6,711,310	8,312,322	0.404329	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,219	760,625	761,844	1.004392	0.000000	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,130,353	2,130,353			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	65,876	6,219,070	6,284,946	0.554509	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	772,897	772,897	1.731024	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	9,521,931	57,840,716	67,362,647			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,521,931	57,840,716	67,362,647			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 4:11 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
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
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
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
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
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
		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
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 2/27/2017 4:11 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	295,579	4,271,150	0.069204	360,209	24,928	50.00
51.00	05100	RECOVERY ROOM	47,560	513,029	0.092704	40,837	3,786	51.00
53.00	05300	ANESTHESIOLOGY	19,138	1,275,386	0.015006	97,012	1,456	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	267,474	5,908,662	0.045268	207,320	9,385	54.00
56.00	05600	RADIOISOTOPE	55,962	1,653,844	0.033838	25,639	868	56.00
57.00	05700	CT SCAN	45,447	8,959,134	0.005073	147,135	746	57.00
58.00	05800	MRI	69,211	2,887,166	0.023972	98,355	2,358	58.00
60.00	06000	LABORATORY	204,033	11,156,025	0.018289	429,566	7,856	60.00
64.00	06400	INTRAVENOUS THERAPY	272,309	776,027	0.350901	944	331	64.00
65.00	06500	RESPIRATORY THERAPY	154,171	1,030,513	0.149606	234,845	35,134	65.00
66.00	06600	PHYSICAL THERAPY	155,830	2,749,690	0.056672	58,168	3,296	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,748	711,487	0.054461	16,537	901	67.00
68.00	06800	SPEECH PATHOLOGY	8,336	202,004	0.041267	3,897	161	68.00
69.00	06900	ELECTROCARDIOLOGY	9,565	1,905,160	0.005021	24,691	124	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	164,981	2,103,062	0.078448	691,744	54,266	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	148,237	8,312,322	0.017833	330,378	5,892	73.00
75.00	07500	ASC (NON-DISTINCT PART)	251,651	761,844	0.330318	575	190	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	435,218	2,130,353	0.204294	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	407,696	6,284,946	0.064869	85	6	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	298,556	772,897	0.386282	0	0	92.00
200.00		Total (lines 50-199)	3,349,702	64,364,701		2,767,937	151,684	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/27/2017 4:11 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	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		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
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/27/2017 4:11 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	4,271,150	0.000000	0.000000	360,209	50.00
51.00	05100	RECOVERY ROOM	0	513,029	0.000000	0.000000	40,837	51.00
53.00	05300	ANESTHESIOLOGY	0	1,275,386	0.000000	0.000000	97,012	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,908,662	0.000000	0.000000	207,320	54.00
56.00	05600	RADIOISOTOPE	0	1,653,844	0.000000	0.000000	25,639	56.00
57.00	05700	CT SCAN	0	8,959,134	0.000000	0.000000	147,135	57.00
58.00	05800	MRI	0	2,887,166	0.000000	0.000000	98,355	58.00
60.00	06000	LABORATORY	0	11,156,025	0.000000	0.000000	429,566	60.00
64.00	06400	INTRAVENOUS THERAPY	0	776,027	0.000000	0.000000	944	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,030,513	0.000000	0.000000	234,845	65.00
66.00	06600	PHYSICAL THERAPY	0	2,749,690	0.000000	0.000000	58,168	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	711,487	0.000000	0.000000	16,537	67.00
68.00	06800	SPEECH PATHOLOGY	0	202,004	0.000000	0.000000	3,897	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,905,160	0.000000	0.000000	24,691	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,103,062	0.000000	0.000000	691,744	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,312,322	0.000000	0.000000	330,378	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	761,844	0.000000	0.000000	575	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,130,353	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	6,284,946	0.000000	0.000000	85	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	772,897	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	64,364,701			2,767,937	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/27/2017 4:11 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
51.00	05100	RECOVERY ROOM	0	0	0		51.00
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
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
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
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
		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
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/27/2017 4:11 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	0.378317	0	1,151,286	0	0	50.00
51.00	05100	RECOVERY ROOM	0.392128	0	140,772	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.276446	0	365,821	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273194	0	2,010,640	0	0	54.00
56.00	05600	RADIOISOTOPE	0.343125	0	719,703	0	0	56.00
57.00	05700	CT SCAN	0.069023	0	3,236,583	0	0	57.00
58.00	05800	MRI	0.119670	0	929,019	0	0	58.00
60.00	06000	LABORATORY	0.214833	0	4,522,360	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1.373008	0	455,320	4,158	0	64.00
65.00	06500	RESPIRATORY THERAPY	1.033553	0	214,687	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.373339	0	969,519	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.472520	0	76,429	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.494505	0	7,725	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.046108	0	756,804	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.302501	0	277,895	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.404329	0	3,858,166	9,529	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.004392	0	297,131	0	0	75.00
		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	0.554509	0	1,806,714	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.731024	0	547,252	0	0	92.00
200.00		Subtotal (see instructions)		0	22,343,826	13,687	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	22,343,826	13,687	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/27/2017 4:11 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	435,551	0		50.00
51.00	05100	RECOVERY ROOM	55,201	0		51.00
53.00	05300	ANESTHESIOLOGY	101,130	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	549,295	0		54.00
56.00	05600	RADIOISOTOPE	246,948	0		56.00
57.00	05700	CT SCAN	223,399	0		57.00
58.00	05800	MRI	111,176	0		58.00
60.00	06000	LABORATORY	971,552	0		60.00
64.00	06400	INTRAVENOUS THERAPY	625,158	5,709		64.00
65.00	06500	RESPIRATORY THERAPY	221,890	0		65.00
66.00	06600	PHYSICAL THERAPY	361,959	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	36,114	0		67.00
68.00	06800	SPEECH PATHOLOGY	3,820	0		68.00
69.00	06900	ELECTROCARDIOLOGY	34,895	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	84,064	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,559,968	3,853		73.00
75.00	07500	ASC (NON-DISTINCT PART)	298,436	0		75.00
		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	1,001,839	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	947,306	0		92.00
200.00		Subtotal (see instructions)	7,869,701	9,562		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	7,869,701	9,562		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1310 | Component CCN: 14-Z310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/27/2017 4:11 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	0.378317	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.392128	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.276446	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273194	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.343125	0	0	0	0	56.00
57.00	05700	CT SCAN	0.069023	0	0	0	0	57.00
58.00	05800	MRI	0.119670	0	0	0	0	58.00
60.00	06000	LABORATORY	0.214833	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1.373008	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1.033553	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.373339	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.472520	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.494505	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.046108	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.302501	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.404329	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.004392	0	0	0	0	75.00
		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	0.554509	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.731024	0	0	0	0	92.00
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: 14-1310 | Component CCN: 14-Z310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V | Date/Time Prepared: 2/27/2017 4:11 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
51.00	05100	RECOVERY ROOM	0	0	51.00
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
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
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
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
		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
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: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 4:11 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)	2,823	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,815	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,172	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	171	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)	512	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	81	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)	244	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	721	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)	171	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)	436	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	143.61	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	150.15	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,245,904	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)	11,632	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)	36,637	25.00
26.00	Total swing-bed cost (see instructions)	1,469,401	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,776,503	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,776,503	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,080.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,500,199	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,500,199	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 4:11 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	672,089	95	7,074.62	70	495,223	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)	978,827	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,974,249	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)	355,803	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	907,194	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,262,997	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)	643	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,080.72	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,337,903	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 4:11 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	1,170,633	5,245,904	0.223152	1,337,903	298,556	90.00
91.00	Nursing School cost	0	5,245,904	0.000000	1,337,903	0	91.00
92.00	Allied health cost	0	5,245,904	0.000000	1,337,903	0	92.00
93.00	All other Medical Education	0	5,245,904	0.000000	1,337,903	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/27/2017 4:11 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		858,651		30.00
31.00	03100	INTENSIVE CARE UNIT		144,432		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.378317	360,209	136,273	50.00
51.00	05100	RECOVERY ROOM	0.392128	40,837	16,013	51.00
53.00	05300	ANESTHESIOLOGY	0.276446	97,012	26,819	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273194	207,320	56,639	54.00
56.00	05600	RADIOISOTOPE	0.343125	25,639	8,797	56.00
57.00	05700	CT SCAN	0.069023	147,135	10,156	57.00
58.00	05800	MRI	0.119670	98,355	11,770	58.00
60.00	06000	LABORATORY	0.214833	429,566	92,285	60.00
64.00	06400	INTRAVENOUS THERAPY	1.373008	944	1,296	64.00
65.00	06500	RESPIRATORY THERAPY	1.033553	234,845	242,725	65.00
66.00	06600	PHYSICAL THERAPY	0.373339	58,168	21,716	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.472520	16,537	7,814	67.00
68.00	06800	SPEECH PATHOLOGY	0.494505	3,897	1,927	68.00
69.00	06900	ELECTROCARDIOLOGY	0.046108	24,691	1,138	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.302501	691,744	209,253	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.404329	330,378	133,581	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.004392	575	578	75.00
		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	0.554509	85	47	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.731024	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,767,937	978,827	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)		2,767,937		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3

Component CCN: 14-Z310 | Date/Time Prepared: 2/27/2017 4:11 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
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.378317	0	0	50.00
51.00	05100	RECOVERY ROOM	0.392128	247	97	51.00
53.00	05300	ANESTHESIOLOGY	0.276446	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273194	28,550	7,800	54.00
56.00	05600	RADIOISOTOPE	0.343125	1,715	588	56.00
57.00	05700	CT SCAN	0.069023	9,699	669	57.00
58.00	05800	MRI	0.119670	2,633	315	58.00
60.00	06000	LABORATORY	0.214833	153,768	33,034	60.00
64.00	06400	INTRAVENOUS THERAPY	1.373008	470	645	64.00
65.00	06500	RESPIRATORY THERAPY	1.033553	120,076	124,105	65.00
66.00	06600	PHYSICAL THERAPY	0.373339	178,717	66,722	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.472520	57,404	27,125	67.00
68.00	06800	SPEECH PATHOLOGY	0.494505	1,061	525	68.00
69.00	06900	ELECTROCARDIOLOGY	0.046108	1,601	74	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.302501	130,743	39,550	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.404329	110,636	44,733	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.004392	0	0	75.00
		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	0.554509	35	19	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.731024	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		797,355	346,001	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)		797,355		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1310	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 2/27/2017 4:11 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,879,263	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)	7,879,263	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)	7,958,056	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)	55,795	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,559,966	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)	4,342,295	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)	4,342,295	30.00
31.00	Primary payer payments	5,681	31.00
32.00	Subtotal (line 30 minus line 31)	4,336,614	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)	560,666	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	364,433	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	324,218	36.00
37.00	Subtotal (see instructions)	4,701,047	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,701,047	40.00
40.01	Sequestration adjustment (see instructions)	94,021	40.01
41.00	Interim payments	4,756,796	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-149,770	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: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 2/27/2017 4:11 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		2,534,232		4,751,735	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	05/19/2016	5,061	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	05/19/2016	10,075		0	3.50
3.51		09/22/2016	7,333		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)		-17,408		5,061	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)		2,516,824		4,756,796	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		157,649		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		149,770	6.02
7.00	Total Medicare program liability (see instructions)		2,674,473		4,607,026	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: 14-1310 | Component CCN: 14-Z310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 2/27/2017 4:11 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		1,573,744		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	05/19/2016	29,052		0	3.01
3.02		09/22/2016	14,282		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)		43,334		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)		1,617,078		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		25,438		0	6.02
7.00	Total Medicare program liability (see instructions)		1,591,640		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 - SWING BEDS

Provider CCN: 14-1310 | Component CCN: 14-Z310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-2 | Date/Time Prepared: 2/27/2017 4:11 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)	1,275,627	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)	349,461	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	607	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)	1,625,088	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,625,088	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)	1,625,088	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	966	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)	1,624,122	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,624,122	0	19.00
19.01	Sequestration adjustment (see instructions)	32,482	0	19.01
20.00	Interim payments	1,617,078	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)	-25,438	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: 14-1310	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part V Date/Time Prepared: 2/27/2017 4:11 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,974,249	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)	2,974,249	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,984,064	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)	2,984,064	19.00
20.00	Deductibles (exclude professional component)	277,774	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,706,290	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,706,290	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	35,021	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	22,764	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	16,460	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,729,054	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	2,729,054	30.00
30.01	Sequestration adjustment (see instructions)	54,581	30.01
31.00	Interim payments	2,516,824	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)	157,649	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	117,825	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G | Date/Time Prepared: 2/27/2017 4:11 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	2,466,905	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	14,819,908	0	0	0	4.00
5.00	Other receivable	84,555	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,767,573	0	0	0	6.00
7.00	Inventory	810,048	0	0	0	7.00
8.00	Prepaid expenses	598,705	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	260,380	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,272,928	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,927,000	0	0	0	12.00
13.00	Land improvements	2,405,200	0	0	0	13.00
14.00	Accumulated depreciation	-1,723,510	0	0	0	14.00
15.00	Buildings	17,332,300	0	0	0	15.00
16.00	Accumulated depreciation	-7,080,003	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	3,882,374	0	0	0	19.00
20.00	Accumulated depreciation	0	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	11,651,470	0	0	0	23.00
24.00	Accumulated depreciation	-13,488,830	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)	14,906,001	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,655,418	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	13,780,335	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	15,435,753	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	38,614,682	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,597,339	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,417,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,285,193	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	456,147	0	0	0	43.00
44.00	Other current liabilities	1,138,564	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,894,243	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	29,549,807	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	25,100	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	29,574,907	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	36,469,150	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	2,145,532				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)	2,145,532	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	38,614,682	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-1 | Date/Time Prepared: 2/27/2017 4:11 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		-9,619,772		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		892,822				2.00
3.00	Total (sum of line 1 and line 2)		-8,726,950		0		3.00
4.00	TOTAL CHANGE IN NET ASSESTS	10,855,261		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)		10,855,261		0		10.00
11.00	Subtotal (line 3 plus line 10)		2,128,311		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)		2,128,311		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	TOTAL CHANGE IN NET ASSESTS		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: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/27/2017 4:11 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,846,490		1,846,490	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	937,034		937,034	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,783,524		2,783,524	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	214,422		214,422	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)	214,422		214,422	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,997,946		2,997,946	17.00
18.00	Ancillary services	6,457,208	48,719,297	55,176,505	18.00
19.00	Outpatient services	65,876	6,991,967	7,057,843	19.00
20.00	RURAL HEALTH CLINIC	0	2,130,353	2,130,353	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				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	274,035	8,147,885	8,421,920	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,795,065	65,989,502	75,784,567	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		34,131,201		29.00
30.00	MISC RECONCILIING EXPENSE ACCOUNTS	17,221			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)		17,221		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)		34,148,422		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1310 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-3 | Date/Time Prepared: 2/27/2017 4:11 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	75,784,567	1.00
2.00	Less contractual allowances and discounts on patients' accounts	41,587,419	2.00
3.00	Net patient revenues (line 1 minus line 2)	34,197,148	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	34,148,422	4.00
5.00	Net income from service to patients (line 3 minus line 4)	48,726	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	372,184	6.00
7.00	Income from investments	13,018	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	8,466	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	61,836	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	10,164	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	26,063	20.00
21.00	Rental of vending machines	1,570	21.00
22.00	Rental of hospital space	17,382	22.00
23.00	Governmental appropriations	145,439	23.00
24.00	OTHER INCOME	98,790	24.00
24.01	HPSA AND OTHER PHYSICIAN INCOME	103,539	24.01
24.02	DIETICIAN REVENUE	9,198	24.02
25.00	Total other income (sum of lines 6-24)	867,649	25.00
26.00	Total (line 5 plus line 25)	916,375	26.00
27.00	LOSS ON DISPOSAL OF ASSETS	23,553	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	23,553	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	892,822	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1310 | Component CCN: 14-8535 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1 | Date/Time Prepared: 2/27/2017 4:11 pm

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	380,377	0	380,377	0	380,377	1.00
2.00	Physician Assistant	139,862	0	139,862	0	139,862	2.00
3.00	Nurse Practitioner	163,971	0	163,971	0	163,971	3.00
4.00	Visiting Nurse	543,757	0	543,757	0	543,757	4.00
5.00	Other Nurse	73,705	0	73,705	0	73,705	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	60,486	0	60,486	0	60,486	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,362,158	0	1,362,158	0	1,362,158	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	3,162	3,162	0	3,162	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	3,162	3,162	0	3,162	14.00
15.00	Medical Supplies	0	87,920	87,920	0	87,920	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	87,920	87,920	0	87,920	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,362,158	91,082	1,453,240	0	1,453,240	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	25,166	83	25,249	0	25,249	29.00
30.00	Administrative Costs	183,894	166,564	350,458	-2,021	348,437	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	209,060	166,647	375,707	-2,021	373,686	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,571,218	257,729	1,828,947	-2,021	1,826,926	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1310 | Component CCN: 14-8535 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1 | Date/Time Prepared: 2/27/2017 4:11 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	380,377		1.00
2.00	Physician Assistant	0	139,862		2.00
3.00	Nurse Practitioner	0	163,971		3.00
4.00	Visiting Nurse	0	543,757		4.00
5.00	Other Nurse	0	73,705		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	60,486		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,362,158		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	3,162		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	3,162		14.00
15.00	Medical Supplies	0	87,920		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	87,920		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,453,240		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	25,249		29.00
30.00	Administrative Costs	0	348,437		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	373,686		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,826,926		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1310 | Component CCN: 14-8535 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-2 | Date/Time Prepared: 2/27/2017 4:11 pm

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	1.75	3,313	4,200	7,350		1.00
2.00	Physician Assistant	1.37	3,174	2,100	2,877		2.00
3.00	Nurse Practitioner	1.47	5,489	2,100	3,087		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.59	11,976		13,314	13,314	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.59	11,976			13,314	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,453,240	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,453,240	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					373,686	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,667,444	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,041,130	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,041,130	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,041,130	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,494,370	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1310 Component CCN: 14-8535	Period: From 10/01/2015 To 09/30/2016	Worksheet M-3 Date/Time Prepared: 2/27/2017 4:11 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		3,494,370	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		1,286,816	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,207,554	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		13,314	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)		13,314	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		165.81	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)	165.81	165.81	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,490	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	744,487	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)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	744,487	16.00
16.01	Total program charges (see instructions)(from contractor's records)		681,775	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.)		571,322	16.04
16.05	Total program cost (see instructions)	0	571,322	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		30,334	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		121,757	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		571,322	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		198,367	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		769,689	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		769,689	26.00
26.01	Sequestration adjustment (see instructions)		15,394	26.01
27.00	Interim payments		593,801	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)		160,494	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 HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 14-1310 | Component CCN: 14-8535 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-4 | Date/Time Prepared: 2/27/2017 4:11 pm

Title XVIII | RHC I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,362,158	1,362,158	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.166667	0.166667	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	227,027	227,027	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	66,759	14,349	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	293,786	241,376	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,453,240	1,453,240	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,041,130	2,041,130	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.202159	0.166095	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	412,633	339,021	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	706,419	580,397	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	447	394	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	1,580.36	1,473.09	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	64	66	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	101,143	97,224	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)		1,286,816	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)		198,367	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1310 Component CCN: 14-8535	Period: From 10/01/2015 To 09/30/2016	Worksheet M-5 Date/Time Prepared: 2/27/2017 4:11 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		491,037	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		05/19/2016	52,608	3.01
3.02		09/22/2016	50,156	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		102,764	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		593,801	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		160,494	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		754,295	7.00

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