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: 14-1315	Period: From 10/01/2015 To 09/30/2016	Worksheet S Parts I-III Date/Time Prepared: 2/25/2017 11:35 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: — Time:
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 BCC DBA ILLINI COMMUNITY HOSPITAL (14-1315) 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

		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	45,039	-54,547	0	0	1.00
2.00	Subprovider - IPF	0	0	-50		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-2,573	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		105,471		0	10.00
200.00	Total	0	42,466	50,874	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2017 11:35 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 640 WEST WASHINGTON	PO Box:			1.00
2.00	City: PITTSFIELD	State: IL	Zip Code: 62363	County: PIKE	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	BCC DBA ILLINI COMMUNITY HOSPITAL	141315	99914	1	09/01/2001	N	O	N	3.00
4.00	Subprovider - IPF	BCC DBA ILLINI COMM HOSP GERIPSYCH	14M315	99914	4	10/01/2015	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	BCC DBA ILLINI COMM HOSP-SWINGBED	14Z315	99914		09/01/2001	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									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	BCC DBA ILLINI COMM HOSP-RHC	143482	99914		07/03/2006	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	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.	0		23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2017 11:35 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)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

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

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

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

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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: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2017 11:35 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.	Y			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)	N		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)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	89,924	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	14H132	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: BLESSING CORPORATE SERVICES	Contractor's Name: NATIONAL GOVERNMENT SERVICES	Contractor's Number: 00131	141.00
142.00	Street: BROADWAY AT 11TH STREET	PO Box:		142.00
143.00	City: QUINCY	State: IL	Zip Code: 62301	143.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2017 11:35 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.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						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)					10/01/2015	09/30/2016	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: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 2/25/2017 11:35 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/31/2016	Y	12/31/2016	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 2/25/2017 11:35 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				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONNIE		ZIEGLER		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLESSING CORPORATE SERVICES				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-223-8400, X4159		CZIEGLER@BLESSINGHOSPITAL.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1315	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Prepared: 2/25/2017 11:35 pm

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

HFS Supplemental Information | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part IX Date/Time Prepared: 2/25/2017 11:35 pm

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00
	RHC			
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2017 11:35 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	25	9,150	18,264.00	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)		25	9,150	18,264.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,150	18,264.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,660		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		35				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: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2017 11:35 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)	577	50	759			1.00
2.00	HMO and other (see instructions)	84	0				2.00
3.00	HMO IPF Subprovider	66	17				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	218	0	218			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		37	37			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	795	87	1,014			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)	795	87	1,014	0.00	156.08	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	585	133	1,093	0.00	20.94	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,876	0	6,193	0.00	9.55	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	186.57	27.00
28.00	Observation Bed Days		20	108			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			20			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: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2017 11:35 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	170	25	245	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				6		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	170	25	245	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	89	38	181	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	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: 14-1315 | Component CCN: 14-3482 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-8 | Date/Time Prepared: 2/25/2017 11:35 pm

			RHC I	Cost
			1.00	
	Clinic Address and Identification			
1.00	Street		640 WEST WASHINGTON	1.00
		City	State	ZIP Code
		1.00	2.00	3.00
2.00	City, State, ZIP Code, County	PITTSFIELD	IL	62363 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			07:00	17:30	07:00 11.00
					1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?				N	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0 13.00
				Provider name		CCN number
				1.00		2.00
14.00	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		PIKE			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	17:30	07:00	17:30	07:00	17:30 11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1315
Component CCN: 14-3482

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

Worksheet S-8
Date/Time Prepared:
2/25/2017 11:35 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	07:00	17:30	07:00	12:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-10 | Date/Time Prepared: 2/25/2017 11:35 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)	0.398383	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,242,765	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	1,591,122	5.00
6.00	Medicaid charges	13,321,732	6.00
7.00	Medicaid cost (line 1 times line 6)	5,307,152	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)	1,473,265	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)	1,473,265	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)	292,418	145,968	438,386	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	116,494	58,151	174,645	21.00
22.00	Partial payment by patients approved for charity care	1,406	393	1,799	22.00
23.00	Cost of charity care (line 21 minus line 22)	115,088	57,758	172,846	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)	1,491,605	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	328,938	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,162,667	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	463,187	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	636,033	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,109,298	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/25/2017 11:35 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		486,640	486,640	134,904	621,544	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		376,173	376,173	3,405	379,578	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,027,838	3,027,838	0	3,027,838	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,548,335	1,979,920	3,528,255	-36,158	3,492,097	5.00
6.00	00600	MAINTENANCE & REPAIRS	473,958	544,938	1,018,896	0	1,018,896	6.00
7.00	00700	OPERATION OF PLANT	0	353,112	353,112	40,171	393,283	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	119,140	119,140	0	119,140	8.00
9.00	00900	HOUSEKEEPING	307,598	50,274	357,872	0	357,872	9.00
10.00	01000	DIETARY	181,836	138,974	320,810	0	320,810	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	357,687	22,731	380,418	-125,997	254,421	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,606	215,932	243,538	0	243,538	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	19,542	19,542	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	82,310	82,310	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	806,359	60,109	866,468	-22,491	843,977	30.00
40.00	04000	SUBPROVIDER - IPF	931,853	47,491	979,344	-200	979,144	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	648,341	192,138	840,479	-132,158	708,321	50.00
53.00	05300	ANESTHESIOLOGY	82,310	13,625	95,935	-95,935	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	681,178	451,707	1,132,885	-640	1,132,245	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	77,599	58,846	136,445	-17,971	118,474	54.01
60.00	06000	LABORATORY	510,707	790,055	1,300,762	-45,624	1,255,138	60.00
65.00	06500	RESPIRATORY THERAPY	133,650	43,367	177,017	-18,984	158,033	65.00
65.01	06501	SLEEP STUDIES	0	36,457	36,457	0	36,457	65.01
66.00	06600	PHYSICAL THERAPY	27,207	31,398	58,605	0	58,605	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,450	82,979	121,429	122,045	243,474	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	369,435	2,724,053	3,093,488	-227	3,093,261	73.00
73.01	07301	ONCOLOGY	0	272,407	272,407	118,991	391,398	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	540,538	533,394	1,073,932	142,112	1,216,044	88.00
91.00	09100	EMERGENCY	803,196	2,076,744	2,879,940	-8,236	2,871,704	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		97,976	97,976	-85,409	12,567	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,547,843	14,828,418	23,376,261	73,450	23,449,711	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	75,689	20,952	96,641	0	96,641	192.00
192.01	19201	XPRESS CARE	272,505	41,158	313,663	0	313,663	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	0	0	0	0	0	193.02
193.03	19303	LEASED SPACE	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	0	0	0	193.04
193.05	19305	WELLNESS	157,874	64,151	222,025	-73,450	148,575	193.05
200.00		TOTAL (SUM OF LINES 118-199)	9,053,911	14,954,679	24,008,590	0	24,008,590	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/25/2017 11:35 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	186,463	808,007		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	203,263	582,841		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-467,989	2,559,849		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	451,069	3,943,166		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,018,896		6.00
7.00	00700	OPERATION OF PLANT	-401	392,882		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-751	118,389		8.00
9.00	00900	HOUSEKEEPING	0	357,872		9.00
10.00	01000	DIETARY	-54,586	266,224		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	254,421		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	67,287	310,825		16.00
17.00	01700	SOCIAL SERVICE	0	19,542		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	82,310		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-11,931	832,046		30.00
40.00	04000	SUBPROVIDER - IPF	0	979,144		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	708,321		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-14,532	1,117,713		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	118,474		54.01
60.00	06000	LABORATORY	-178,975	1,076,163		60.00
65.00	06500	RESPIRATORY THERAPY	0	158,033		65.00
65.01	06501	SLEEP STUDIES	-9,518	26,939		65.01
66.00	06600	PHYSICAL THERAPY	0	58,605		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,146	242,328		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,047	3,143,308		73.00
73.01	07301	ONCOLOGY	-272,250	119,148		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	29,426	1,245,470		88.00
91.00	09100	EMERGENCY	-1,516,920	1,354,784		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-12,567	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,554,011	21,895,700		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	96,641		192.00
192.01	19201	XPRESS CARE	0	313,663		192.01
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0		193.01
193.02	19302	RENAL	0	0		193.02
193.03	19303	LEASED SPACE	0	0		193.03
193.04	19304	UNUSED SPACE	0	0		193.04
193.05	19305	WELLNESS	0	148,575		193.05
200.00		TOTAL (SUM OF LINES 118-199)	-1,554,011	22,454,579		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet Non-CMS W | Date/Time Prepared: 2/25/2017 11:35 pm

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
40.00	SUBPROVIDER - IPF	04000		40.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
54.01	NUCLEAR MEDICINE-DIAGNOSTIC	05401		54.01
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
65.01	SLEEP STUDIES	06501		65.01
66.00	PHYSICAL THERAPY	06600		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
73.01	ONCOLOGY	07301		73.01
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	08800		88.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	XPRESS CARE	19201		192.01
193.00	NONPAID WORKERS	19300		193.00
193.01	AUTOMATED HEALTH SERVICES	19301		193.01
193.02	RENAL	19302		193.02
193.03	LEASED SPACE	19303		193.03
193.04	UNUSED SPACE	19304		193.04
193.05	WELLNESS	19305		193.05
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/25/2017 11:35 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	10,000	1.00
	TOTALS		0	10,000	
	B - RECLASS UTILITIES				
1.00	OPERATION OF PLANT	7.00	0	40,171	1.00
	TOTALS		0	40,171	
	C - RECLASS MEDICAL SUPPLIES EXPENSE				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	122,045	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
	TOTALS		0	122,045	
	D - RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	85,409	1.00
	TOTALS		0	85,409	
	E - RECLASS SOCIAL SERVICE SALARY				
1.00	SOCIAL SERVICE	17.00	19,542	0	1.00
	TOTALS		19,542	0	
	F - RECLASS MISCELLANEOUS ANESTH EXPENSE				
1.00	OPERATING ROOM	50.00	0	13,295	1.00
	TOTALS		0	13,295	
	G - RECLASS RHC PHYSICIAN PAYMENT				
1.00	RURAL HEALTH CLINIC	88.00	0	142,534	1.00
	TOTALS		0	142,534	
	H - RECLASS CRNA COSTS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	82,310	0	1.00
	TOTALS		82,310	0	
	I - RECLASS UR COORDINATOR SALARY				
1.00	ADMINISTRATIVE & GENERAL	5.00	33,499	0	1.00
	TOTALS		33,499	0	
	J - RECLASS NURSING MANAGER SALARY				
1.00	ADMINISTRATIVE & GENERAL	5.00	92,498	0	1.00
	TOTALS		92,498	0	
	K - RECLASS BUILDING RENT				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	42,900	1.00
	TOTALS		0	42,900	
	L - RECLASS EMPLOYEE BENEFIT PERCENTAGE				
1.00	ADMINISTRATIVE & GENERAL	5.00	21,723	8,827	1.00
	TOTALS		21,723	8,827	
	M - RECLASS ONCOLOGY COSTS				
1.00	ONCOLOGY	73.01	109,388	9,603	1.00
	TOTALS		109,388	9,603	
500.00	Grand Total: Increases		358,960	474,784	500.00

RECLASSIFICATIONS | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/25/2017 11:35 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,000	0		1.00
	TOTALS		0	10,000			
	B - RECLASS UTILITIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	40,171	0		1.00
	TOTALS		0	40,171			
	C - RECLASS MEDICAL SUPPLIES EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	2,949	0		1.00
2.00	SUBPROVIDER - IPF	40.00	0	200	0		2.00
3.00	OPERATING ROOM	50.00	0	26,462	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	330	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	640	0		5.00
6.00	NUCLEAR MEDICINE-DIAGNOSTIC	54.01	0	17,971	0		6.00
7.00	LABORATORY	60.00	0	45,624	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	18,984	0		8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	227	0		9.00
10.00	EMERGENCY	91.00	0	8,236	0		10.00
11.00	RURAL HEALTH CLINIC	88.00	0	422	0		11.00
	TOTALS		0	122,045			
	D - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	85,409	11		1.00
	TOTALS		0	85,409			
	E - RECLASS SOCIAL SERVICE SALARY						
1.00	ADULTS & PEDIATRICS	30.00	19,542	0	0		1.00
	TOTALS		19,542	0			
	F - RECLASS MISCELLANEOUS ANESTH EXPENSE						
1.00	ANESTHESIOLOGY	53.00	0	13,295	0		1.00
	TOTALS		0	13,295			
	G - RECLASS RHC PHYSICIAN PAYMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	142,534	0		1.00
	TOTALS		0	142,534			
	H - RECLASS CRNA COSTS						
1.00	ANESTHESIOLOGY	53.00	82,310	0	0		1.00
	TOTALS		82,310	0			
	I - RECLASS UR COORDINATOR SALARY						
1.00	NURSING ADMINISTRATION	13.00	33,499	0	0		1.00
	TOTALS		33,499	0			
	J - RECLASS NURSING MANAGER SALARY						
1.00	NURSING ADMINISTRATION	13.00	92,498	0	0		1.00
	TOTALS		92,498	0			
	K - RECLASS BUILDING RENT						
1.00	WELLNESS	193.05	0	42,900	10		1.00
	TOTALS		0	42,900			
	L - RECLASS EMPLOYEE BENEFIT PERCENTAGE						
1.00	WELLNESS	193.05	21,723	8,827	0		1.00
	TOTALS		21,723	8,827			
	M - RECLASS ONCOLOGY COSTS						
1.00	OPERATING ROOM	50.00	109,388	9,603	0		1.00
	TOTALS		109,388	9,603			
500.00	Grand Total: Decreases		358,960	474,784			500.00

RECLASSIFICATIONS | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 2/25/2017 11:35 pm

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - RECLASS PROPERTY INSURANCE								
1.00	OTHER CAP REL COSTS	3.00	0	10,000	ADMINISTRATIVE & GENERAL	5.00	0	10,000	1.00
	TOTALS		0	10,000	TOTALS		0	10,000	
	B - RECLASS UTILITIES								
1.00	OPERATION OF PLANT	7.00	0	40,171	ADMINISTRATIVE & GENERAL	5.00	0	40,171	1.00
	TOTALS		0	40,171	TOTALS		0	40,171	
	C - RECLASS MEDICAL SUPPLIES EXPENSE								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	122,045	ADULTS & PEDIATRICS	30.00	0	2,949	1.00
2.00		0.00	0	0	SUBPROVIDER - IPF	40.00	0	200	2.00
3.00		0.00	0	0	OPERATING ROOM	50.00	0	26,462	3.00
4.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	330	4.00
5.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	640	5.00
6.00		0.00	0	0	NUCLEAR MEDICINE-DIAGNOSTIC	54.01	0	17,971	6.00
7.00		0.00	0	0	LABORATORY	60.00	0	45,624	7.00
8.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	18,984	8.00
9.00		0.00	0	0	DRUGS CHARGED TO PATIENTS	73.00	0	227	9.00
10.00		0.00	0	0	EMERGENCY	91.00	0	8,236	10.00
11.00		0.00	0	0	RURAL HEALTH CLINIC	88.00	0	422	11.00
	TOTALS		0	122,045	TOTALS		0	122,045	
	D - RECLASS INTEREST EXPENSE								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	85,409	INTEREST EXPENSE	113.00	0	85,409	1.00
	TOTALS		0	85,409	TOTALS		0	85,409	
	E - RECLASS SOCIAL SERVICE SALARY								
1.00	SOCIAL SERVICE	17.00	19,542	0	ADULTS & PEDIATRICS	30.00	19,542	0	1.00
	TOTALS		19,542	0	TOTALS		19,542	0	
	F - RECLASS MISCELLANEOUS ANESTH EXPENSE								
1.00	OPERATING ROOM	50.00	0	13,295	ANESTHESIOLOGY	53.00	0	13,295	1.00
	TOTALS		0	13,295	TOTALS		0	13,295	
	G - RECLASS RHC PHYSICIAN PAYMENT								
1.00	RURAL HEALTH CLINIC	88.00	0	142,534	ADMINISTRATIVE & GENERAL	5.00	0	142,534	1.00
	TOTALS		0	142,534	TOTALS		0	142,534	
	H - RECLASS CRNA COSTS								
1.00	NONPHYSICIAN ANESTHETISTS	19.00	82,310	0	ANESTHESIOLOGY	53.00	82,310	0	1.00
	TOTALS		82,310	0	TOTALS		82,310	0	
	I - RECLASS UR COORDINATOR SALARY								
1.00	ADMINISTRATIVE & GENERAL	5.00	33,499	0	NURSING ADMINISTRATION	13.00	33,499	0	1.00
	TOTALS		33,499	0	TOTALS		33,499	0	
	J - RECLASS NURSING MANAGER SALARY								
1.00	ADMINISTRATIVE & GENERAL	5.00	92,498	0	NURSING ADMINISTRATION	13.00	92,498	0	1.00
	TOTALS		92,498	0	TOTALS		92,498	0	
	K - RECLASS BUILDING RENT								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	42,900	WELLNESS	193.05	0	42,900	1.00
	TOTALS		0	42,900	TOTALS		0	42,900	
	L - RECLASS EMPLOYEE BENEFIT PERCENTAGE								
1.00	ADMINISTRATIVE & GENERAL	5.00	21,723	8,827	WELLNESS	193.05	21,723	8,827	1.00
	TOTALS		21,723	8,827	TOTALS		21,723	8,827	
	M - RECLASS ONCOLOGY COSTS								
1.00	ONCOLOGY	73.01	109,388	9,603	OPERATING ROOM	50.00	109,388	9,603	1.00
	TOTALS		109,388	9,603	TOTALS		109,388	9,603	
500.00	Grand Total: Increases		358,960	474,784	Grand Total: Decreases		358,960	474,784	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 2/25/2017 11:35 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	263,851	15,840	0	15,840	0	1.00
2.00	Land Improvements	559,684	17,304	0	17,304	0	2.00
3.00	Buildings and Fixtures	10,155,026	2,650,857	0	2,650,857	0	3.00
4.00	Building Improvements	1,041,231	327,145	0	327,145	101,421	4.00
5.00	Fixed Equipment	0	46,901	0	46,901	0	5.00
6.00	Movable Equipment	7,468,812	708,667	0	708,667	888,555	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	19,488,604	3,766,714	0	3,766,714	989,976	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	19,488,604	3,766,714	0	3,766,714	989,976	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	279,691	0	1.00
2.00	Land Improvements	576,988	0	2.00
3.00	Buildings and Fixtures	12,805,883	0	3.00
4.00	Building Improvements	1,266,955	0	4.00
5.00	Fixed Equipment	46,901	0	5.00
6.00	Movable Equipment	7,288,924	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	22,265,342	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	22,265,342	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 2/25/2017 11:35 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	486,640	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	376,173	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	862,813	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	486,640		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	376,173		2.00
3.00	Total (sum of lines 1-2)	0	862,813		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 2/25/2017 11:35 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	14,119,739	0	14,119,739	0.659534	6,595	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,288,924	0	7,288,924	0.340466	3,405	2.00
3.00	Total (sum of lines 1-2)	21,408,663	0	21,408,663	1.000000	10,000	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	6,595	673,103	42,900	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	3,405	579,436	0	2.00
3.00	Total (sum of lines 1-2)	0	0	10,000	1,252,539	42,900	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	85,409	6,595	0	0	808,007	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,405	0	0	582,841	2.00
3.00	Total (sum of lines 1-2)	85,409	10,000	0	0	1,390,848	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/25/2017 11:35 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-12,567	INTEREST EXPENSE	113.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		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	-1,789,170			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	158,830			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-231	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	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
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-13,206	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-17,459	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/25/2017 11:35 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	
33.01	MISCELLANOUS SUPPLIES REVENUE	B	-1,146	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.01
33.02	PHYSICIAN RECRUITMENT	A	-181	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	CABLE TELEVISION	A	-401	OPERATION OF PLANT	7.00	0	33.03
33.04	MISCELLANOUS EXPENSE	A	-22,446	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	PUBLIC RELATIONS SALARIES	A	-45,724	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PUBLIC RELATIONS EMPLOYEE BENEFITS	A	-15,291	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	PUBLIC RELATIONS EXPENSES	A	-127,709	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	ASSET RELIFING	A	186,463	CAP REL COSTS-BLDG & FIXT	1.00	9	33.08
33.09	ASSET RELIFING	A	216,469	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.09
33.10	COFFEE SHOP RECEIPTS	B	-53,292	DIETARY	10.00	0	33.10
33.11	MEALS ON WHEELS	B	-2,255	DIETARY	10.00	0	33.11
33.12	LOBBYING EXPENSE	A	-9,787	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	MISCELLANEOUS	B	-1,286	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	MISCELLANEOUS	B	-1,971	RURAL HEALTH CLINIC	88.00	0	33.14
33.15	ACCOUNTING FEES	B	-1,651	ADMINISTRATIVE & GENERAL	5.00	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,554,011				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: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 2/25/2017 11:35 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1,214,018	724,216	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	241,119	173,601	2.00
3.00	10.00	DIETARY	DIETICIAN	5,332	4,371	3.00
4.00	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	74,314	75,065	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	0	452,698	4.01
4.02	88.00	RURAL HEALTH CLINIC	RHC PHYSICIAN	516,600	485,203	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	ACCOUNTS PAYABLE COSTS	7,048	9,333	4.03
4.04	54.00	RADIOLOGY-DIAGNOSTIC	ECHO SERVICES	6,781	21,313	4.04
4.05	73.00	DRUGS CHARGED TO PATIENTS	PHARMACY SERVICES	86,047	36,000	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	INFORMATICS	196,395	6,600	4.06
4.07	30.00	ADULTS & PEDIATRICS	CARE MANAGEMENT	0	11,931	4.07
4.08	60.00	LABORATORY	LABORATORY TESTS	99,049	278,024	4.08
4.09	65.01	SLEEP STUDIES	SLEEP STUDIES	26,501	36,019	4.09
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,473,204	2,314,374	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	BLESSING CORP S	0.00	6.00
7.00	G		0.00	BLESSING HOSP	0.00	7.00
8.00	G		0.00	DENMAN SERVICES	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:	BROTHER/SISTER				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: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 2/25/2017 11:35 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	489,802	0		1.00
2.00	67,518	0		2.00
3.00	961	0		3.00
4.00	-751	0		4.00
4.01	-452,698	0		4.01
4.02	31,397	0		4.02
4.03	-2,285	0		4.03
4.04	-14,532	0		4.04
4.05	50,047	0		4.05
4.06	189,795	0		4.06
4.07	-11,931	0		4.07
4.08	-178,975	0		4.08
4.09	-9,518	0		4.09
5.00	158,830			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			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: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 2/25/2017 11:35 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	25,594	0	25,594	0	0	1.00
2.00	60.00	LABORATORY	2,896	0	2,896	0	0	2.00
3.00	73.01	ONCOLOGY	272,250	272,250	0	0	0	3.00
4.00	91.00	EMERGENCY	2,013,087	1,516,920	496,167	0	0	4.00
5.00	13.00	NURSING ADMINISTRATION	3,100	0	3,100	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			2,316,927	1,789,170	527,757		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	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	73.01	ONCOLOGY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	13.00	NURSING ADMINISTRATION	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	0		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	73.01	ONCOLOGY	0	0	0	272,250		3.00
4.00	91.00	EMERGENCY	0	0	0	1,516,920		4.00
5.00	13.00	NURSING ADMINISTRATION	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	1,789,170		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1315	Period: From 10/01/2015 To 09/30/2016	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/25/2017 11:35 pm

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					174	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					3.45	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	249.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	78.94	59.21	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)	39.47	39.47	29.61			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)					19,696	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)					19,696	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)					19,696	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)					78.94	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					61,573	22.00
23.00	Total salary equivalency (see instructions)					61,573	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)					6,868	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)					6,868	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)					600	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					7,468	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)					0	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: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/25/2017 11:35 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)	78.94	59.21	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)	61,573		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		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)	61,573		63.00
64.00	Total cost of outside supplier services (from your records)	23,798		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	6,868		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	600		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	7,468		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	600		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	600		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: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/25/2017 11:35 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	808,007	808,007				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	582,841		582,841			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,559,849	0	0	2,559,849		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,943,166	203,823	154,663	468,976	4,770,628	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,018,896	148,604	112,763	134,684	1,414,947	6.00
7.00	00700	OPERATION OF PLANT	392,882	0	0	0	392,882	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	118,389	6,438	4,885	0	129,712	8.00
9.00	00900	HOUSEKEEPING	357,872	11,382	8,637	87,410	465,301	9.00
10.00	01000	DIETARY	266,224	13,056	9,907	51,672	340,859	10.00
11.00	01100	CAFETERIA	0	3,739	2,837	0	6,576	11.00
13.00	01300	NURSING ADMINISTRATION	254,421	1,256	953	65,839	322,469	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	310,825	10,241	7,771	7,845	336,682	16.00
17.00	01700	SOCIAL SERVICE	19,542	902	685	5,553	26,682	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	82,310	0	0	23,390	105,700	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	832,046	44,098	33,462	223,589	1,133,195	30.00
40.00	04000	SUBPROVIDER - IPF	979,144	30,291	22,985	264,804	1,297,224	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	708,321	39,111	29,678	153,154	930,264	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,117,713	22,301	16,923	193,570	1,350,507	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	118,474	3,176	2,410	22,051	146,111	54.01
60.00	06000	LABORATORY	1,076,163	14,095	10,696	145,127	1,246,081	60.00
65.00	06500	RESPIRATORY THERAPY	158,033	5,413	4,107	37,979	205,532	65.00
65.01	06501	SLEEP STUDIES	26,939	751	570	0	28,260	65.01
66.00	06600	PHYSICAL THERAPY	58,605	0	0	7,731	66,336	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	242,328	6,856	5,203	10,926	265,313	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,143,308	8,856	6,720	104,982	3,263,866	73.00
73.01	07301	ONCOLOGY	119,148	25,102	19,048	31,085	194,383	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,245,470	44,257	33,582	153,604	1,476,913	88.00
91.00	09100	EMERGENCY	1,354,784	37,270	28,281	228,243	1,648,578	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,895,700	681,018	516,766	2,422,214	21,565,001	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	96,641	22,742	17,257	21,508	158,148	192.00
192.01	19201	XPRESS CARE	313,663	0	10,608	77,437	401,708	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	0	12,204	0	0	12,204	193.02
193.03	19303	LEASED SPACE	0	39,840	0	0	39,840	193.03
193.04	19304	UNUSED SPACE	0	1,848	0	0	1,848	193.04
193.05	19305	WELLNESS	148,575	50,355	38,210	38,690	275,830	193.05
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)	22,454,579	808,007	582,841	2,559,849	22,454,579	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/25/2017 11:35 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,770,628					5.00
6.00	00600	MAINTENANCE & REPAIRS	381,713	1,796,660				6.00
7.00	00700	OPERATION OF PLANT	105,989	0	498,871			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,993	24,730	7,050	196,485		8.00
9.00	00900	HOUSEKEEPING	125,525	43,722	12,463	0	647,011	9.00
10.00	01000	DIETARY	91,954	50,154	14,297	0	18,777	10.00
11.00	01100	CAFETERIA	1,774	14,361	4,094	0	5,377	11.00
13.00	01300	NURSING ADMINISTRATION	86,993	4,824	1,375	0	1,806	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	90,827	39,341	11,215	0	14,729	16.00
17.00	01700	SOCIAL SERVICE	7,198	3,466	988	0	1,297	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	28,515	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	305,704	169,397	48,288	95,517	63,419	30.00
40.00	04000	SUBPROVIDER - IPF	349,955	116,360	33,170	100,968	43,563	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	250,959	150,239	42,827	0	56,247	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	364,329	85,669	24,421	0	32,073	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	39,417	12,199	3,477	0	4,567	54.01
60.00	06000	LABORATORY	336,158	54,146	15,435	0	20,271	60.00
65.00	06500	RESPIRATORY THERAPY	55,447	20,793	5,927	0	7,785	65.00
65.01	06501	SLEEP STUDIES	7,624	2,883	822	0	1,079	65.01
66.00	06600	PHYSICAL THERAPY	17,896	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71,574	26,338	7,508	0	9,861	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	880,491	34,018	9,697	0	12,736	73.00
73.01	07301	ONCOLOGY	52,439	96,426	27,487	0	36,100	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	398,430	170,007	48,462	0	63,648	88.00
91.00	09100	EMERGENCY	444,740	143,169	40,812	0	53,600	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,530,644	1,262,242	359,815	196,485	446,935	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	42,664	87,360	24,903	0	32,706	192.00
192.01	19201	XPRESS CARE	108,370	53,702	0	0	20,105	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	3,292	46,882	13,364	0	17,552	193.02
193.03	19303	LEASED SPACE	10,748	153,039	43,625	0	57,295	193.03
193.04	19304	UNUSED SPACE	499	0	2,023	0	0	193.04
193.05	19305	WELLNESS	74,411	193,435	55,141	0	72,418	193.05
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)	4,770,628	1,796,660	498,871	196,485	647,011	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/25/2017 11:35 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	516,041					10.00
11.00	01100	CAFETERIA	0	32,182				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,246	418,713			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	148	0	492,942		16.00
17.00	01700	SOCIAL SERVICE	0	105	0	0	39,736	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	442	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	250,863	4,230	116,483	24,417	19,317	30.00
40.00	04000	SUBPROVIDER - IPF	265,178	5,012	54,714	21,451	20,419	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,897	57,273	22,952	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,135	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,662	56	140,269	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	417	3,450	6,778	0	54.01
60.00	06000	LABORATORY	0	2,746	0	79,103	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	719	10,325	19,089	0	65.00
65.01	06501	SLEEP STUDIES	0	0	0	3,396	0	65.01
66.00	06600	PHYSICAL THERAPY	0	146	0	1,492	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	207	0	10,531	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,986	0	83,753	0	73.00
73.01	07301	ONCOLOGY	0	588	12,321	5,400	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,906	39,676	0	0	88.00
91.00	09100	EMERGENCY	0	4,318	113,661	72,176	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	516,041	31,775	407,959	492,942	39,736	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	407	10,691	0	0	192.00
192.01	19201	XPRESS CARE	0	0	63	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	0	0	0	0	0	193.02
193.03	19303	LEASED SPACE	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	0	0	0	193.04
193.05	19305	WELLNESS	0	0	0	0	0	193.05
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)	516,041	32,182	418,713	492,942	39,736	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/25/2017 11:35 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	134,657					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,230,830	0	2,230,830		30.00
40.00	04000	SUBPROVIDER - IPF	0	2,308,014	0	2,308,014		40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,513,658	0	1,513,658		50.00
53.00	05300	ANESTHESIOLOGY	134,657	136,792	0	136,792		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,000,986	0	2,000,986		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	216,416	0	216,416		54.01
60.00	06000	LABORATORY	0	1,753,940	0	1,753,940		60.00
65.00	06500	RESPIRATORY THERAPY	0	325,617	0	325,617		65.00
65.01	06501	SLEEP STUDIES	0	44,064	0	44,064		65.01
66.00	06600	PHYSICAL THERAPY	0	85,870	0	85,870		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	391,332	0	391,332		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,286,547	0	4,286,547		73.00
73.01	07301	ONCOLOGY	0	425,144	0	425,144		73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,200,042	0	2,200,042		88.00
91.00	09100	EMERGENCY	0	2,521,054	0	2,521,054		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	134,657	20,440,306	0	20,440,306		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	356,879	0	356,879		192.00
192.01	19201	XPRESS CARE	0	583,948	0	583,948		192.01
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0		193.01
193.02	19302	RENAL	0	93,294	0	93,294		193.02
193.03	19303	LEASED SPACE	0	304,547	0	304,547		193.03
193.04	19304	UNUSED SPACE	0	4,370	0	4,370		193.04
193.05	19305	WELLNESS	0	671,235	0	671,235		193.05
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	134,657	22,454,579	0	22,454,579		202.00

COST ALLOCATION STATISTICS | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet Non-CMS W | Date/Time Prepared: 2/25/2017 11:35 pm

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	6	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	7	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	9	SQUARE FEET	9.00
10.00	DIETARY	8	PATIENT DAYS	10.00
11.00	CAFETERIA	11	GROSS SALARIES	11.00
13.00	NURSING ADMINISTRATION	13	NURSING SALARIES	13.00
16.00	MEDICAL RECORDS & LIBRARY	16	TOTAL CHARGES	16.00
17.00	SOCIAL SERVICE	8	PATIENT DAYS	17.00
19.00	NONPHYSICIAN ANESTHETISTS	19	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/25/2017 11:35 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	203,823	154,663	358,486	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	148,604	112,763	261,367	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,438	4,885	11,323	0	8.00
9.00	00900	HOUSEKEEPING	0	11,382	8,637	20,019	0	9.00
10.00	01000	DIETARY	0	13,056	9,907	22,963	0	10.00
11.00	01100	CAFETERIA	0	3,739	2,837	6,576	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,256	953	2,209	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,241	7,771	18,012	0	16.00
17.00	01700	SOCIAL SERVICE	0	902	685	1,587	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	44,098	33,462	77,560	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	30,291	22,985	53,276	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	39,111	29,678	68,789	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,301	16,923	39,224	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	3,176	2,410	5,586	0	54.01
60.00	06000	LABORATORY	0	14,095	10,696	24,791	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,413	4,107	9,520	0	65.00
65.01	06501	SLEEP STUDIES	0	751	570	1,321	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,856	5,203	12,059	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,856	6,720	15,576	0	73.00
73.01	07301	ONCOLOGY	0	25,102	19,048	44,150	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	44,257	33,582	77,839	0	88.00
91.00	09100	EMERGENCY	0	37,270	28,281	65,551	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	681,018	516,766	1,197,784	0	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	22,742	17,257	39,999	0	192.00
192.01	19201	XPRESS CARE	21,180	0	10,608	31,788	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	0	12,204	0	12,204	0	193.02
193.03	19303	LEASED SPACE	0	39,840	0	39,840	0	193.03
193.04	19304	UNUSED SPACE	0	1,848	0	1,848	0	193.04
193.05	19305	WELLNESS	0	50,355	38,210	88,565	0	193.05
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)	21,180	808,007	582,841	1,412,028	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/25/2017 11:35 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	358,486					5.00
6.00	00600	MAINTENANCE & REPAIRS	28,684	290,051				6.00
7.00	00700	OPERATION OF PLANT	7,965	0	7,965			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,630	3,992	113	18,058		8.00
9.00	00900	HOUSEKEEPING	9,433	7,058	199	0	36,709	9.00
10.00	01000	DIETARY	6,910	8,097	228	0	1,065	10.00
11.00	01100	CAFETERIA	133	2,318	65	0	305	11.00
13.00	01300	NURSING ADMINISTRATION	6,537	779	22	0	102	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,825	6,351	179	0	836	16.00
17.00	01700	SOCIAL SERVICE	541	559	16	0	74	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	2,143	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,972	27,347	771	8,779	3,598	30.00
40.00	04000	SUBPROVIDER - IPF	26,297	18,785	530	9,279	2,472	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,858	24,254	684	0	3,191	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,377	13,830	390	0	1,820	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	2,962	1,969	56	0	259	54.01
60.00	06000	LABORATORY	25,261	8,741	246	0	1,150	60.00
65.00	06500	RESPIRATORY THERAPY	4,167	3,357	95	0	442	65.00
65.01	06501	SLEEP STUDIES	573	465	13	0	61	65.01
66.00	06600	PHYSICAL THERAPY	1,345	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,378	4,252	120	0	559	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,161	5,492	155	0	723	73.00
73.01	07301	ONCOLOGY	3,941	15,567	439	0	2,048	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	29,940	27,446	774	0	3,611	88.00
91.00	09100	EMERGENCY	33,420	23,113	652	0	3,041	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	340,453	203,772	5,747	18,058	25,357	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	3,206	14,103	398	0	1,856	192.00
192.01	19201	XPRESS CARE	8,143	8,670	0	0	1,141	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	247	7,569	213	0	996	193.02
193.03	19303	LEASED SPACE	808	24,707	697	0	3,251	193.03
193.04	19304	UNUSED SPACE	37	0	32	0	0	193.04
193.05	19305	WELLNESS	5,592	31,230	878	0	4,108	193.05
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)	358,486	290,051	7,965	18,058	36,709	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/25/2017 11:35 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	39,263					10.00
11.00	01100	CAFETERIA	0	9,397				11.00
13.00	01300	NURSING ADMINISTRATION	0	364	10,013			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	43	0	32,246		16.00
17.00	01700	SOCIAL SERVICE	0	31	0	0	2,808	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	129	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,087	1,235	2,785	1,596	1,365	30.00
40.00	04000	SUBPROVIDER - IPF	20,176	1,462	1,308	1,402	1,443	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	846	1,370	1,500	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	140	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,069	1	9,192	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	122	83	443	0	54.01
60.00	06000	LABORATORY	0	802	0	5,171	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	210	247	1,248	0	65.00
65.01	06501	SLEEP STUDIES	0	0	0	222	0	65.01
66.00	06600	PHYSICAL THERAPY	0	43	0	98	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	60	0	688	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	580	0	5,475	0	73.00
73.01	07301	ONCOLOGY	0	172	295	353	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	849	949	0	0	88.00
91.00	09100	EMERGENCY	0	1,261	2,718	4,718	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,263	9,278	9,756	32,246	2,808	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	119	256	0	0	192.00
192.01	19201	XPRESS CARE	0	0	1	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	0	0	0	0	0	193.02
193.03	19303	LEASED SPACE	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	0	0	0	193.04
193.05	19305	WELLNESS	0	0	0	0	0	193.05
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)	39,263	9,397	10,013	32,246	2,808	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/25/2017 11:35 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	2,272					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		167,095	0	167,095		30.00
40.00	04000	SUBPROVIDER - IPF		136,430	0	136,430		40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		119,492	0	119,492		50.00
53.00	05300	ANESTHESIOLOGY		140	0	140		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		92,903	0	92,903		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC		11,480	0	11,480		54.01
60.00	06000	LABORATORY		66,162	0	66,162		60.00
65.00	06500	RESPIRATORY THERAPY		19,286	0	19,286		65.00
65.01	06501	SLEEP STUDIES		2,655	0	2,655		65.01
66.00	06600	PHYSICAL THERAPY		1,486	0	1,486		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		23,116	0	23,116		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		94,162	0	94,162		73.00
73.01	07301	ONCOLOGY		66,965	0	66,965		73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		141,408	0	141,408		88.00
91.00	09100	EMERGENCY		134,474	0	134,474		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,077,254	0	1,077,254		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		59,937	0	59,937		192.00
192.01	19201	XPRESS CARE		49,743	0	49,743		192.01
193.00	19300	NONPAID WORKERS		0	0	0		193.00
193.01	19301	AUTOMATED HEALTH SERVICES		0	0	0		193.01
193.02	19302	RENAL		21,229	0	21,229		193.02
193.03	19303	LEASED SPACE		69,303	0	69,303		193.03
193.04	19304	UNUSED SPACE		1,917	0	1,917		193.04
193.05	19305	WELLNESS		130,373	0	130,373		193.05
200.00		Cross Foot Adjustments	2,272	2,272	0	2,272		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	2,272	1,412,028	0	1,412,028		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/25/2017 11:35 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	111,954					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		106,424				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	9,008,186			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,241	28,241	1,650,331	-4,770,628	17,683,951	5.00
6.00	00600	MAINTENANCE & REPAIRS	20,590	20,590	473,958	0	1,414,947	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	392,882	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	892	892	0	0	129,712	8.00
9.00	00900	HOUSEKEEPING	1,577	1,577	307,598	0	465,301	9.00
10.00	01000	DIETARY	1,809	1,809	181,836	0	340,859	10.00
11.00	01100	CAFETERIA	518	518	0	0	6,576	11.00
13.00	01300	NURSING ADMINISTRATION	174	174	231,690	0	322,469	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,419	1,419	27,606	0	336,682	16.00
17.00	01700	SOCIAL SERVICE	125	125	19,542	0	26,682	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	82,310	0	105,700	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,110	6,110	786,817	0	1,133,195	30.00
40.00	04000	SUBPROVIDER - IPF	4,197	4,197	931,853	0	1,297,224	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,419	5,419	538,953	0	930,264	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,090	3,090	681,178	0	1,350,507	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	440	440	77,599	0	146,111	54.01
60.00	06000	LABORATORY	1,953	1,953	510,707	0	1,246,081	60.00
65.00	06500	RESPIRATORY THERAPY	750	750	133,650	0	205,532	65.00
65.01	06501	SLEEP STUDIES	104	104	0	0	28,260	65.01
66.00	06600	PHYSICAL THERAPY	0	0	27,207	0	66,336	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	950	950	38,450	0	265,313	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,227	1,227	369,435	0	3,263,866	73.00
73.01	07301	ONCOLOGY	3,478	3,478	109,388	0	194,383	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,132	6,132	540,538	0	1,476,913	88.00
91.00	09100	EMERGENCY	5,164	5,164	803,196	0	1,648,578	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	94,359	94,359	8,523,842	-4,770,628	16,794,373	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	3,151	3,151	75,689	0	158,148	192.00
192.01	19201	XPRESS CARE	0	1,937	272,504	0	401,708	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	1,691	0	0	0	12,204	193.02
193.03	19303	LEASED SPACE	5,520	0	0	0	39,840	193.03
193.04	19304	UNUSED SPACE	256	0	0	0	1,848	193.04
193.05	19305	WELLNESS	6,977	6,977	136,151	0	275,830	193.05
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)	808,007	582,841	2,559,849		4,770,628	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.217312	5.476594	0.284169		0.269772	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		358,486	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.020272	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/25/2017 11:35 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	64,804					6.00
7.00	00700	OPERATION OF PLANT	0	63,123				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	892	892	2,127			8.00
9.00	00900	HOUSEKEEPING	1,577	1,577	0	62,335		9.00
10.00	01000	DIETARY	1,809	1,809	0	1,809	2,127	10.00
11.00	01100	CAFETERIA	518	518	0	518	0	11.00
13.00	01300	NURSING ADMINISTRATION	174	174	0	174	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,419	1,419	0	1,419	0	16.00
17.00	01700	SOCIAL SERVICE	125	125	0	125	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,110	6,110	1,034	6,110	1,034	30.00
40.00	04000	SUBPROVIDER - IPF	4,197	4,197	1,093	4,197	1,093	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,419	5,419	0	5,419	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,090	3,090	0	3,090	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	440	440	0	440	0	54.01
60.00	06000	LABORATORY	1,953	1,953	0	1,953	0	60.00
65.00	06500	RESPIRATORY THERAPY	750	750	0	750	0	65.00
65.01	06501	SLEEP STUDIES	104	104	0	104	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	950	950	0	950	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,227	1,227	0	1,227	0	73.00
73.01	07301	ONCOLOGY	3,478	3,478	0	3,478	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,132	6,132	0	6,132	0	88.00
91.00	09100	EMERGENCY	5,164	5,164	0	5,164	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	45,528	45,528	2,127	43,059	2,127	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	3,151	3,151	0	3,151	0	192.00
192.01	19201	XPRESS CARE	1,937	0	0	1,937	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	1,691	1,691	0	1,691	0	193.02
193.03	19303	LEASED SPACE	5,520	5,520	0	5,520	0	193.03
193.04	19304	UNUSED SPACE	0	256	0	0	0	193.04
193.05	19305	WELLNESS	6,977	6,977	0	6,977	0	193.05
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)	1,796,660	498,871	196,485	647,011	516,041	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.724523	7.903157	92.376587	10.379578	242.614480	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	290,051	7,965	18,058	36,709	39,263	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.475819	0.126182	8.489892	0.588899	18.459332	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/25/2017 11:35 pm

		Cost Center Description	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (TOTAL CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	5,985,808					11.00
13.00	01300	NURSING ADMINISTRATION	231,690	2,409,215				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,606	0	49,726,546			16.00
17.00	01700	SOCIAL SERVICE	19,542	0	0	2,127		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	82,310	0	0	0	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	786,817	670,223	2,463,098	1,034	0	30.00
40.00	04000	SUBPROVIDER - IPF	931,853	314,819	2,163,882	1,093	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	538,953	329,543	2,315,309	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	215,332	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	681,178	323	14,149,798	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	77,599	19,852	683,759	0	0	54.01
60.00	06000	LABORATORY	510,707	0	7,979,685	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	133,650	59,406	1,925,682	0	0	65.00
65.01	06501	SLEEP STUDIES	0	0	342,583	0	0	65.01
66.00	06600	PHYSICAL THERAPY	27,207	0	150,488	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,450	0	1,062,378	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	369,435	0	8,448,821	0	0	73.00
73.01	07301	ONCOLOGY	109,388	70,894	544,752	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	540,538	228,288	0	0	0	88.00
91.00	09100	EMERGENCY	803,196	653,993	7,280,979	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,910,119	2,347,341	49,726,546	2,127	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	75,689	61,514	0	0	0	192.00
192.01	19201	XPRESS CARE	0	360	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	0	0	0	0	0	193.02
193.03	19303	LEASED SPACE	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	0	0	0	193.04
193.05	19305	WELLNESS	0	0	0	0	0	193.05
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)	32,182	418,713	492,942	39,736	134,657	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.005376	0.173796	0.009913	18.681711	1,346.570000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,397	10,013	32,246	2,808	2,272	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001570	0.004156	0.000648	1.320169	22.720000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/25/2017 11:35 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	2,230,830		2,230,830	0	2,230,830	30.00
40.00	04000	SUBPROVIDER - IPF	2,308,014		2,308,014	0	2,308,014	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,513,658		1,513,658	0	1,513,658	50.00
53.00	05300	ANESTHESIOLOGY	136,792		136,792	0	136,792	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,000,986		2,000,986	0	2,000,986	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	216,416		216,416	0	216,416	54.01
60.00	06000	LABORATORY	1,753,940		1,753,940	0	1,753,940	60.00
65.00	06500	RESPIRATORY THERAPY	325,617	0	325,617	0	325,617	65.00
65.01	06501	SLEEP STUDIES	44,064	0	44,064	0	44,064	65.01
66.00	06600	PHYSICAL THERAPY	85,870	0	85,870	0	85,870	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	391,332		391,332	0	391,332	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,286,547		4,286,547	0	4,286,547	73.00
73.01	07301	ONCOLOGY	425,144		425,144	0	425,144	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,200,042		2,200,042	0	2,200,042	88.00
91.00	09100	EMERGENCY	2,521,054		2,521,054	0	2,521,054	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	221,530		221,530		221,530	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	20,661,836	0	20,661,836	0	20,661,836	200.00
201.00		Less Observation Beds	221,530		221,530		221,530	201.00
202.00		Total (see instructions)	20,440,306	0	20,440,306	0	20,440,306	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/25/2017 11:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,910,162		1,910,162			30.00
40.00	04000	SUBPROVIDER - IPF	2,163,882		2,163,882			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,580	2,306,729	2,315,309	0.653761	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	215,332	215,332	0.635261	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	378,091	13,771,707	14,149,798	0.141414	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	683,759	683,759	0.316509	0.000000	54.01
60.00	06000	LABORATORY	513,543	7,466,142	7,979,685	0.219801	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	474,889	1,450,793	1,925,682	0.169092	0.000000	65.00
65.01	06501	SLEEP STUDIES	0	342,583	342,583	0.128623	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	120,574	29,914	150,488	0.570610	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	120,819	941,559	1,062,378	0.368355	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	537,524	7,911,297	8,448,821	0.507354	0.000000	73.00
73.01	07301	ONCOLOGY	0	544,752	544,752	0.780436	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,581,586	1,581,586			88.00
91.00	09100	EMERGENCY	29,274	7,251,705	7,280,979	0.346252	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	552,936	552,936	0.400643	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,257,338	45,050,794	51,308,132			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,257,338	45,050,794	51,308,132			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/25/2017 11:35 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
40.00	04000	SUBPROVIDER - IPF			40.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.653761		50.00
53.00	05300	ANESTHESIOLOGY	0.635261		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141414		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.316509		54.01
60.00	06000	LABORATORY	0.219801		60.00
65.00	06500	RESPIRATORY THERAPY	0.169092		65.00
65.01	06501	SLEEP STUDIES	0.128623		65.01
66.00	06600	PHYSICAL THERAPY	0.570610		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.368355		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.507354		73.00
73.01	07301	ONCOLOGY	0.780436		73.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
91.00	09100	EMERGENCY	0.346252		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.400643		92.00
		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: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 2/25/2017 11:35 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	119,492	2,315,309	0.051610	6,434	332	50.00
53.00	05300	ANESTHESIOLOGY	140	215,332	0.000650	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	92,903	14,149,798	0.006566	200,521	1,317	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	11,480	683,759	0.016790	0	0	54.01
60.00	06000	LABORATORY	66,162	7,979,685	0.008291	255,128	2,115	60.00
65.00	06500	RESPIRATORY THERAPY	19,286	1,925,682	0.010015	272,110	2,725	65.00
65.01	06501	SLEEP STUDIES	2,655	342,583	0.007750	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,486	150,488	0.009875	35,067	346	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,116	1,062,378	0.021759	74,182	1,614	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	94,162	8,448,821	0.011145	238,225	2,655	73.00
73.01	07301	ONCOLOGY	66,965	544,752	0.122927	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	141,408	1,581,586	0.089409	0	0	88.00
91.00	09100	EMERGENCY	134,474	7,280,979	0.018469	1,727	32	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	16,593	552,936	0.030009	0	0	92.00
200.00		Total (lines 50-199)	790,322	47,234,088		1,083,394	11,136	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/25/2017 11:35 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
53.00	05300	ANESTHESIOLOGY	134,657	0	0	0	134,657	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP STUDIES	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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)	134,657	0	0	0	134,657	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/25/2017 11:35 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	2,315,309	0.000000	0.000000	6,434	50.00
53.00	05300	ANESTHESIOLOGY	0	215,332	0.625346	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,149,798	0.000000	0.000000	200,521	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	683,759	0.000000	0.000000	0	54.01
60.00	06000	LABORATORY	0	7,979,685	0.000000	0.000000	255,128	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,925,682	0.000000	0.000000	272,110	65.00
65.01	06501	SLEEP STUDIES	0	342,583	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	150,488	0.000000	0.000000	35,067	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,062,378	0.000000	0.000000	74,182	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,448,821	0.000000	0.000000	238,225	73.00
73.01	07301	ONCOLOGY	0	544,752	0.000000	0.000000	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,581,586	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	7,280,979	0.000000	0.000000	1,727	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	552,936	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	47,234,088			1,083,394	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/25/2017 11:35 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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP STUDIES	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/25/2017 11:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
			23.00	24.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	54.01
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
65.01	06501	SLEEP STUDIES	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	07301	ONCOLOGY	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/25/2017 11:35 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	0.653761	0	1,071,408	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.635261	0	37,487	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141414	0	5,293,791	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.316509	0	381,351	0	0	54.01
60.00	06000	LABORATORY	0.219801	0	2,988,511	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.169092	0	742,710	0	0	65.00
65.01	06501	SLEEP STUDIES	0.128623	0	98,267	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.570610	0	13,752	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.368355	0	481,321	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.507354	0	5,511,051	1,285	0	73.00
73.01	07301	ONCOLOGY	0.780436	0	363,759	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.346252	0	2,401,585	1,291	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.400643	0	289,203	0	0	92.00
200.00		Subtotal (see instructions)		0	19,674,196	2,576	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	19,674,196	2,576	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/25/2017 11:35 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	700,445	0		50.00
53.00	05300	ANESTHESIOLOGY	23,814	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	748,616	0		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	120,701	0		54.01
60.00	06000	LABORATORY	656,878	0		60.00
65.00	06500	RESPIRATORY THERAPY	125,586	0		65.00
65.01	06501	SLEEP STUDIES	12,639	0		65.01
66.00	06600	PHYSICAL THERAPY	7,847	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	177,297	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,796,054	652		73.00
73.01	07301	ONCOLOGY	283,891	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	831,554	447		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	115,867	0		92.00
200.00		Subtotal (see instructions)	6,601,189	1,099		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	6,601,189	1,099		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II | Date/Time Prepared: 2/25/2017 11:35 pm

Title XVIII | Subprovider - IPF | PPS

		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	119,492	2,315,309	0.051610	0	0	50.00
53.00	05300	ANESTHESIOLOGY	140	215,332	0.000650	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	92,903	14,149,798	0.006566	30,968	203	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	11,480	683,759	0.016790	0	0	54.01
60.00	06000	LABORATORY	66,162	7,979,685	0.008291	44,256	367	60.00
65.00	06500	RESPIRATORY THERAPY	19,286	1,925,682	0.010015	12,272	123	65.00
65.01	06501	SLEEP STUDIES	2,655	342,583	0.007750	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,486	150,488	0.009875	3,924	39	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,116	1,062,378	0.021759	1,208	26	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	94,162	8,448,821	0.011145	84,521	942	73.00
73.01	07301	ONCOLOGY	66,965	544,752	0.122927	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	141,408	1,581,586	0.089409	0	0	88.00
91.00	09100	EMERGENCY	134,474	7,280,979	0.018469	4,034	75	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	552,936	0.000000	0	0	92.00
200.00		Total (lines 50-199)	773,729	47,234,088		181,183	1,775	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/25/2017 11:35 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	134,657	0	0	0	134,657	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP STUDIES	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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)	134,657	0	0	0	134,657	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/25/2017 11:35 pm

Title XVIII | Subprovider - IPF | PPS

		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	2,315,309	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	215,332	0.625346	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,149,798	0.000000	0.000000	30,968	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	683,759	0.000000	0.000000	0	54.01
60.00	06000	LABORATORY	0	7,979,685	0.000000	0.000000	44,256	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,925,682	0.000000	0.000000	12,272	65.00
65.01	06501	SLEEP STUDIES	0	342,583	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	150,488	0.000000	0.000000	3,924	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,062,378	0.000000	0.000000	1,208	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,448,821	0.000000	0.000000	84,521	73.00
73.01	07301	ONCOLOGY	0	544,752	0.000000	0.000000	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,581,586	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	7,280,979	0.000000	0.000000	4,034	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	552,936	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	47,234,088			181,183	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/25/2017 11:35 pm

Title XVIII | Subprovider - IPF | PPS

		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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP STUDIES	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/25/2017 11:35 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0		54.01
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	06501	SLEEP STUDIES	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	07301	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V | Date/Time Prepared: 2/25/2017 11:35 pm

Title XVIII | Subprovider - IPF | PPS

		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	0.653761	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.635261	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141414	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.316509	0	0	0	0	54.01
60.00	06000	LABORATORY	0.219801	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.169092	0	0	0	0	65.00
65.01	06501	SLEEP STUDIES	0.128623	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.570610	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.368355	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.507354	0	0	76	0	73.00
73.01	07301	ONCOLOGY	0.780436	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.346252	0	0	77	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.400643	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	153	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	153	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V | Date/Time Prepared: 2/25/2017 11:35 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0		54.01
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	06501	SLEEP STUDIES	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	39		73.00
73.01	07301	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	27		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	66		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	66		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315 | Component CCN: 14-Z315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/25/2017 11:35 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	0.653761	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.635261	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141414	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.316509	0	0	0	0	54.01
60.00	06000	LABORATORY	0.219801	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.169092	0	0	0	0	65.00
65.01	06501	SLEEP STUDIES	0.128623	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.570610	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.368355	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.507354	0	0	0	0	73.00
73.01	07301	ONCOLOGY	0.780436	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.346252	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.400643	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: 14-1315 | Component CCN: 14-Z315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V | Date/Time Prepared: 2/25/2017 11:35 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0		54.01
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	06501	SLEEP STUDIES	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	07301	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
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: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/25/2017 11:35 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,122	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	867	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)	759	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	54	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)	164	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	9	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)	28	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	577	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)	54	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)	164	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	138.80	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	143.81	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,230,830	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	1,249	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)	4,027	25.00
26.00	Total swing-bed cost (see instructions)	452,438	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,778,392	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,778,392	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)	2,051.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,183,542	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)	1,183,542	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/25/2017 11:35 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	303,448	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,486,990	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)	110,765	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	336,397	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	447,162	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)	108	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,051.20	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	221,530	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/25/2017 11:35 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	167,095	2,230,830	0.074903	221,530	16,593	90.00
91.00	Nursing School cost	0	2,230,830	0.000000	221,530	0	91.00
92.00	Allied health cost	0	2,230,830	0.000000	221,530	0	92.00
93.00	All other Medical Education	0	2,230,830	0.000000	221,530	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 2/25/2017 11:35 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,093	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,093	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)	1,093	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	585	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)	0	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)	0	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,308,014	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)	0	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)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,308,014	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)	2,308,014	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)	2,111.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,235,304	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)	1,235,304	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/25/2017 11:35 pm

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	63,145	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,298,449	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)	1,775	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,775	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,296,674	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)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/25/2017 11:35 pm

Title XVIII | Subprovider - IPF | PPS

	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	0	2,308,014	0.000000	0	0	90.00
91.00	Nursing School cost	0	2,308,014	0.000000	0	0	91.00
92.00	Allied health cost	0	2,308,014	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,308,014	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/25/2017 11:35 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		1,163,586		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.653761	6,434	4,206	50.00
53.00	05300	ANESTHESIOLOGY	0.635261	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141414	200,521	28,356	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.316509	0	0	54.01
60.00	06000	LABORATORY	0.219801	255,128	56,077	60.00
65.00	06500	RESPIRATORY THERAPY	0.169092	272,110	46,012	65.00
65.01	06501	SLEEP STUDIES	0.128623	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.570610	35,067	20,010	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.368355	74,182	27,325	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.507354	238,225	120,864	73.00
73.01	07301	ONCOLOGY	0.780436	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.346252	1,727	598	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.400643	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,083,394	303,448	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)		1,083,394		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/25/2017 11:35 pm

Title XVIII | Subprovider - IPF | PPS

		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
40.00	04000	SUBPROVIDER - IPF		1,156,949		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.653761	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.635261	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141414	30,968	4,379	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.316509	0	0	54.01
60.00	06000	LABORATORY	0.219801	44,256	9,728	60.00
65.00	06500	RESPIRATORY THERAPY	0.169092	12,272	2,075	65.00
65.01	06501	SLEEP STUDIES	0.128623	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.570610	3,924	2,239	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.368355	1,208	445	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.507354	84,521	42,882	73.00
73.01	07301	ONCOLOGY	0.780436	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.346252	4,034	1,397	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.400643	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		181,183	63,145	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)		181,183		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1315 | Component CCN: 14-Z315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/25/2017 11:35 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
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.653761	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.635261	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141414	10,718	1,516	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.316509	0	0	54.01
60.00	06000	LABORATORY	0.219801	35,366	7,773	60.00
65.00	06500	RESPIRATORY THERAPY	0.169092	95,199	16,097	65.00
65.01	06501	SLEEP STUDIES	0.128623	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.570610	58,992	33,661	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.368355	17,593	6,480	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.507354	58,838	29,852	73.00
73.01	07301	ONCOLOGY	0.780436	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.346252	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.400643	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		276,706	95,379	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)		276,706		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1315	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 2/25/2017 11:35 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,602,288	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)	6,602,288	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)	6,668,311	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)	33,516	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,349,810	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)	3,284,985	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)	3,284,985	30.00
31.00	Primary payer payments	200	31.00
32.00	Subtotal (line 30 minus line 31)	3,284,785	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)	477,530	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	310,395	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	435,063	36.00
37.00	Subtotal (see instructions)	3,595,180	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)	3,595,180	40.00
40.01	Sequestration adjustment (see instructions)	71,904	40.01
41.00	Interim payments	3,577,823	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-54,547	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
		Overrides 1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 2/25/2017 11:35 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	66	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)	66	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	153	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)	153	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)	153	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	87	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)	66	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)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	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)	66	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)	66	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	66	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	66	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)	66	40.00
40.01	Sequestration adjustment (see instructions)	1	40.01
41.00	Interim payments	115	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-50	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
		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I Date/Time Prepared: 2/25/2017 11:35 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		1,476,247		3,747,460	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	04/26/2016	111,953	04/26/2016	127,659	3.50
3.51		09/27/2016	59,227	09/27/2016	41,978	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)		-171,180		-169,637	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)		1,305,067		3,577,823	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		45,039		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		54,547	6.02
7.00	Total Medicare program liability (see instructions)		1,350,106		3,523,276	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: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 2/25/2017 11:35 pm

Title XVIII | Subprovider - IPF | PPS

		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		473,690		115	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		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)		0		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)		473,690		115	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		0		50	6.02
7.00	Total Medicare program liability (see instructions)		473,690		65	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: 14-1315 | Component CCN: 14-Z315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 2/25/2017 11:35 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		596,206		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	04/26/2016	23,661		0	3.50
3.51		09/27/2016	39,433		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)		-63,094		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)		533,112		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		2,573		0	6.02
7.00	Total Medicare program liability (see instructions)		530,539		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1315	Period: From 10/01/2015 To 09/30/2016	Worksheet E-1 Part II Date/Time Prepared: 2/25/2017 11:35 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	245	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	577	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	84	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	759	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	51,308,132	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	438,386	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 14-1315 Component CCN: 14-Z315	Period: From 10/01/2015 To 09/30/2016	Worksheet E-2 Date/Time Prepared: 2/25/2017 11:35 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)	451,634	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)	96,333	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	218	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)	547,967	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	547,967	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)	547,967	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,601	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)	541,366	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)	541,366	0	19.00
19.01	Sequestration adjustment (see instructions)	10,827	0	19.01
20.00	Interim payments	533,112	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)	-2,573	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: 14-1315	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part V Date/Time Prepared: 2/25/2017 11:35 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,486,990	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)	1,486,990	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,501,860	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)	1,501,860	19.00
20.00	Deductibles (exclude professional component)	139,524	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,362,336	22.00
23.00	Coinsurance	3,220	23.00
24.00	Subtotal (line 22 minus line 23)	1,359,116	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	28,528	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	18,543	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	26,052	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,377,659	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)	1,377,659	30.00
30.01	Sequestration adjustment (see instructions)	27,553	30.01
31.00	Interim payments	1,305,067	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)	45,039	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part II Date/Time Prepared: 2/25/2017 11:35 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	550,452	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	2.986339	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	550,452	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	550,452	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	550,452	18.00
19.00	Deductibles	61,656	19.00
20.00	Subtotal (line 18 minus line 19)	488,796	20.00
21.00	Coinsurance	5,439	21.00
22.00	Subtotal (line 20 minus line 21)	483,357	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	483,357	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	483,357	31.00
31.01	Sequestration adjustment (see instructions)	9,667	31.01
32.00	Interim payments	473,690	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G | Date/Time Prepared: 2/25/2017 11:35 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	5,727,508	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	10,406,525	0	0	0	4.00
5.00	Other receivable	-174,126	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,715,555	0	0	0	6.00
7.00	Inventory	568,234	0	0	0	7.00
8.00	Prepaid expenses	156,479	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	9,969,065	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	279,691	0	0	0	12.00
13.00	Land improvements	576,987	0	0	0	13.00
14.00	Accumulated depreciation	-349,829	0	0	0	14.00
15.00	Buildings	14,119,739	0	0	0	15.00
16.00	Accumulated depreciation	-4,920,711	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	0	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	7,288,924	0	0	0	23.00
24.00	Accumulated depreciation	-4,838,755	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,156,046	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	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	107,785	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	107,785	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	22,232,896	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	897,087	0	0	0	37.00
38.00	Salaries, wages, and fees payable	703,647	0	0	0	38.00
39.00	Payroll taxes payable	113,574	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	294,060	0	0	0	43.00
44.00	Other current liabilities	1,641,960	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,650,328	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	4,719,594	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	92,847	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,812,441	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,462,769	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	13,770,127				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)	13,770,127	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	22,232,896	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-1 | Date/Time Prepared: 2/25/2017 11:35 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		12,579,939		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,190,188				2.00
3.00	Total (sum of line 1 and line 2)		13,770,127		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		13,770,127		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,770,127		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/25/2017 11:35 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,703,961		1,703,961	1.00
2.00	SUBPROVIDER - IPF	2,278,217		2,278,217	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	179,888		179,888	5.00
6.00	Swing bed - NF	45,385		45,385	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)	4,207,451		4,207,451	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,207,451		4,207,451	17.00
18.00	Ancillary services	2,349,408	0	2,349,408	18.00
19.00	Outpatient services	0	47,905,857	47,905,857	19.00
20.00	RURAL HEALTH CLINIC	0	1,581,586	1,581,586	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				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	XPRESS CARE	0	301,825	301,825	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,556,859	49,789,268	56,346,127	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		24,008,590		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		24,008,590		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1315 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-3 | Date/Time Prepared: 2/25/2017 11:35 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	56,346,127	1.00
2.00	Less contractual allowances and discounts on patients' accounts	31,700,914	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,645,213	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,008,590	4.00
5.00	Net income from service to patients (line 3 minus line 4)	636,623	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	61,970	6.00
7.00	Income from investments	6,661	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	55,546	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	133,620	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	295,768	24.00
25.00	Total other income (sum of lines 6-24)	553,565	25.00
26.00	Total (line 5 plus line 25)	1,190,188	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,190,188	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1315 | Component CCN: 14-3482 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1 | Date/Time Prepared: 2/25/2017 11:35 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	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	206,103	0	206,103	0	206,103	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	292,005	0	292,005	0	292,005	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	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	498,108	0	498,108	0	498,108	10.00
11.00	Physician Services Under Agreement	0	342,669	342,669	142,534	485,203	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	111,650	111,650	0	111,650	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	454,319	454,319	142,534	596,853	14.00
15.00	Medical Supplies	0	422	422	-422	0	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	48,181	48,181	0	48,181	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	48,603	48,603	-422	48,181	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	498,108	502,922	1,001,030	142,112	1,143,142	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	0	1,078	1,078	0	1,078	29.00
30.00	Administrative Costs	42,430	29,394	71,824	0	71,824	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	42,430	30,472	72,902	0	72,902	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	540,538	533,394	1,073,932	142,112	1,216,044	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1315 | Component CCN: 14-3482 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1 | Date/Time Prepared: 2/25/2017 11:35 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	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	206,103		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	292,005		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	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	498,108		10.00
11.00	Physician Services Under Agreement	31,397	516,600		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	111,650		13.00
14.00	Subtotal (sum of lines 11 through 13)	31,397	628,250		14.00
15.00	Medical Supplies	0	0		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	48,181		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	48,181		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	31,397	1,174,539		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	1,078		29.00
30.00	Administrative Costs	-1,971	69,853		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,971	70,931		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	29,426	1,245,470		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1315 | Component CCN: 14-3482 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-2 | Date/Time Prepared: 2/25/2017 11:35 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	0.94	2,435	4,200	3,948		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.64	3,626	2,100	3,444		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.58	6,061		7,392	7,392	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	132			132	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)	2.58	6,193			7,524	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)					1,174,539	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)					1,174,539	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)					70,931	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					954,572	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,025,503	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,025,503	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,025,503	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,200,042	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1315 Component CCN: 14-3482	Period: From 10/01/2015 To 09/30/2016	Worksheet M-3 Date/Time Prepared: 2/25/2017 11:35 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)		2,200,042	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		59,127	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,140,915	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		7,524	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)		7,524	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		284.54	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)	284.54	284.54	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	445	1,373	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	126,620	390,673	11.00
12.00	Program covered visits for mental health services (from contractor records)	31	27	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	8,821	7,683	13.00
14.00	Limit adjustment for mental health services (see instructions)	8,821	7,683	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	533,797	16.00
16.01	Total program charges (see instructions)(from contractor's records)		410,264	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		956	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,244	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.)		399,128	16.04
16.05	Total program cost (see instructions)	0	400,372	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		33,643	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		75,133	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		400,372	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		41,435	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		441,807	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)		441,807	26.00
26.01	Sequestration adjustment (see instructions)		8,836	26.01
27.00	Interim payments		327,500	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)		105,471	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: 14-1315 Component CCN: 14-3482	Period: From 10/01/2015 To 09/30/2016	Worksheet M-4 Date/Time Prepared: 2/25/2017 11:35 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)	498,108	498,108	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001192	0.003895	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	594	1,940	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	20,847	8,185	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	21,441	10,125	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,174,539	1,174,539	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,025,503	1,025,503	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.018255	0.008620	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	18,721	8,840	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	40,162	18,965	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	142	464	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	282.83	40.87	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	115	218	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	32,525	8,910	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)		59,127	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)		41,435	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1315 Component CCN: 14-3482	Period: From 10/01/2015 To 09/30/2016	Worksheet M-5 Date/Time Prepared: 2/25/2017 11:35 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		302,935	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		04/26/2016	14,697	3.01
3.02		09/27/2016	9,868	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)		24,565	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		327,500	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		105,471	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		432,971	7.00

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