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: 14-1320	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/25/2017 2:39 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/25/2017 Time: 2:39 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PARIS COMMUNITY HOSPITAL (14-1320) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-20,524	369,123	1	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	78,213	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		311,321		0	10.00
10.01	RURAL HEALTH CLINIC II	0		37,906		0	10.01
10.02	RURAL HEALTH CLINIC III	0		0		0	10.02
200.00	Total	0	57,689	718,350	1	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2017 2:38 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 721 EAST COURT STREET	PO Box:			1.00
2.00	City: PARIS	State: IL	Zip Code: 61944-	County: EDGAR	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	PARIS COMMUNITY HOSPITAL	141320	99914	1	06/30/2002	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PARIS COMMUNITY HOSPITAL	14Z320	99914		06/30/2002	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	FMC	143987	99914		09/24/1994	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	HATCH	143989	99914		01/01/1995	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	FMC	143431	99914		02/16/1997	N	O	N	15.02
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)	01/01/2016	12/31/2016	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2017 2:38 pm

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				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: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2017 2:38 pm

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

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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.	N		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	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.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N	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: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2017 2:38 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)	1	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)	01/01/2016	12/31/2016	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: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/25/2017 2:38 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/31/2016	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/28/2017	Y	04/28/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/25/2017 2:38 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?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JAKE		CARNAZZO		41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923476		JCARNAZZO@ALLIANTMANAGEMENT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1320	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/25/2017 2:38 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.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/25/2017 2:38 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	3,775	39,216.00	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	3,775	39,216.00	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	3,775	39,216.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2017 2:38 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)	1,057	193	1,634			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	553	0	553			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	2,554			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,610	193	4,741			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,610	193	4,741	0.00	253.17	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	8,760	0	36,398	0.00	66.39	26.00
26.01	RURAL HEALTH CLINIC II	357	0	1,766	0.00	2.98	26.01
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	322.54	27.00
28.00	Observation Bed Days		0	202			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2017 2:38 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	373	71	612	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	373	71	612	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	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 WAGE RELATED COSTS | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part IV Date/Time Prepared: 5/25/2017 2:38 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	1,253,568	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,005,569	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	93,583	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	63,307	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	225,983	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,097,552	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	397,929	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	75,464	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,212,955	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320
Component CCN: 14-3987

Period: From 01/01/2016 To 12/31/2016

Worksheet S-8

Date/Time Prepared: 5/25/2017 2:38 pm

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	727 EAST COURT STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	PARIS	IL	61944	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
9.01				9.01
9.02				9.02
9.03				9.03
9.04				9.04
9.05				9.05
9.06				9.06
9.07				9.07
9.08				9.08
9.09				9.09
9.10				9.10

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

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

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320
Component CCN: 14-3987

Period:
From 01/01/2016
To 12/31/2016

Worksheet S-8

Date/Time Prepared:
5/25/2017 2:38 pm

RHC I | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		EDGAR				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	19:00	08:00	19:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	19:00	08:00	11:30		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320
Component CCN: 14-3989

Period: From 01/01/2016 To 12/31/2016

Worksheet S-8

Date/Time Prepared: 5/25/2017 2:38 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			144 ILLINOIS		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CHRISMAN		IL	61924	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
9.01						9.01
9.02						9.02
9.03						9.03
9.04						9.04
9.05						9.05
9.06						9.06
9.07						9.07
9.08						9.08
9.09						9.09
9.10						9.10
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	12:00	13:30	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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320
Component CCN: 14-3989

Period:
From 01/01/2016
To 12/31/2016

Worksheet S-8

Date/Time Prepared:
5/25/2017 2:38 pm

RHC II | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		EDGAR				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	19:30			08:00	12:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	12:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/25/2017 2:38 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)	0.408729	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,738,463	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	20,132,446	6.00
7.00	Medicaid cost (line 1 times line 6)	8,228,715	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)	3,490,252	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)	3,490,252	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)	295,096	274,842	569,938	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	120,614	112,336	232,950	21.00
22.00	Partial payment by patients approved for charity care	4,848	917	5,765	22.00
23.00	Cost of charity care (line 21 minus line 22)	115,766	111,419	227,185	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)	4,142,495	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	495,048	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	3,647,447	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,490,817	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,718,002	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,208,254	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/25/2017 2:38 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	NEW CAP REL COSTS-BLDG & FIXT		756,196	756,196	196,332	952,528	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,550,349	1,550,349	145,775	1,696,124	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	95,951	5,096,088	5,192,039	-422,450	4,769,589	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	1,932,074	2,569,690	4,501,764	-41,778	4,459,986	5.01
5.02	00560	ADMITTING	609,943	395,102	1,005,045	-248	1,004,797	5.02
7.00	00700	OPERATION OF PLANT	431,529	813,639	1,245,168	-201	1,244,967	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	156,601	156,601	0	156,601	8.00
9.00	00900	HOUSEKEEPING	198,231	73,497	271,728	0	271,728	9.00
10.00	01000	DIETARY	404,603	244,356	648,959	-376,914	272,045	10.00
11.00	01100	CAFETERIA	0	0	0	376,914	376,914	11.00
13.00	01300	NURSING ADMINISTRATION	1,022,935	128,559	1,151,494	0	1,151,494	13.00
15.00	01500	PHARMACY	260,069	1,244,785	1,504,854	-1,204,671	300,183	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	469,250	86,580	555,830	0	555,830	16.00
17.00	01700	SOCIAL SERVICE	54,207	20,494	74,701	0	74,701	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,020,740	387,326	2,408,066	-23,183	2,384,883	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,324,135	2,589,478	3,913,613	-2,164,210	1,749,403	50.00
53.00	05300	ANESTHESIOLOGY	1,099,816	168,789	1,268,605	294,236	1,562,841	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,388,717	844,716	2,233,433	98,084	2,331,517	54.00
60.00	06000	LABORATORY	782,522	1,034,560	1,817,082	-12	1,817,070	60.00
65.00	06500	RESPIRATORY THERAPY	441,377	94,670	536,047	-43,638	492,409	65.00
66.00	06600	PHYSICAL THERAPY	1,068,985	157,044	1,226,029	0	1,226,029	66.00
69.00	06900	ELECTROCARDIOLOGY	0	47,452	47,452	52,721	100,173	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,176	2,176	0	2,176	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	999,423	999,423	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,281,403	1,281,403	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,233,676	1,233,676	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,760,142	766,871	4,527,013	-126,550	4,400,463	88.00
88.01	08801	RURAL HEALTH CLINIC II	219,830	105,606	325,436	-622	324,814	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	92,874	48,933	141,807	-14,568	127,239	90.00
90.01	04951	CHEMO/PAIN	900,117	222,624	1,122,741	0	1,122,741	90.01
90.02	09002	SENIOR CARE	1,480	462,327	463,807	-25,636	438,171	90.02
90.03	09003	SLEEP LAB	57,566	53,456	111,022	-135	110,887	90.03
91.00	09100	EMERGENCY	972,900	2,042,264	3,015,164	0	3,015,164	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		107,236	107,236	-107,236	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,609,993	22,271,464	41,881,457	126,512	42,007,969	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,339,051	970,575	4,309,626	-126,512	4,183,114	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	11,820	11,820	0	11,820	192.01
200.00		TOTAL (SUM OF LINES 118-199)	22,949,044	23,253,859	46,202,903	0	46,202,903	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/25/2017 2:38 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-47,900	904,628		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-154,537	1,541,587		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,769,589		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	-397,981	4,062,005		5.01
5.02	00560	ADMITTING	0	1,004,797		5.02
7.00	00700	OPERATION OF PLANT	0	1,244,967		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	156,601		8.00
9.00	00900	HOUSEKEEPING	0	271,728		9.00
10.00	01000	DIETARY	0	272,045		10.00
11.00	01100	CAFETERIA	-91,587	285,327		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,151,494		13.00
15.00	01500	PHARMACY	0	300,183		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,925	546,905		16.00
17.00	01700	SOCIAL SERVICE	0	74,701		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-671,184	1,713,699		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,749,403		50.00
53.00	05300	ANESTHESIOLOGY	-1,447,852	114,989		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-664,343	1,667,174		54.00
60.00	06000	LABORATORY	0	1,817,070		60.00
65.00	06500	RESPIRATORY THERAPY	0	492,409		65.00
66.00	06600	PHYSICAL THERAPY	0	1,226,029		66.00
69.00	06900	ELECTROCARDIOLOGY	-46,626	53,547		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-1,984	192		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	999,423		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,281,403		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-24,362	1,209,314		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-171,757	4,228,706		88.00
88.01	08801	RURAL HEALTH CLINIC II	-2,075	322,739		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	-13,910	113,329		90.00
90.01	04951	CHEMO/PAIN	-321,377	801,364		90.01
90.02	09002	SENIOR CARE	-3,600	434,571		90.02
90.03	09003	SLEEP LAB	-29,803	81,084		90.03
91.00	09100	EMERGENCY	-1,474,948	1,540,216		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-5,574,751	36,433,218		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-33,096	4,150,018		192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	11,820		192.01
200.00		TOTAL (SUM OF LINES 118-199)	-5,607,847	40,595,056		200.00

RECLASSIFICATIONS | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/25/2017 2:38 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RENTAL EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	145,775		1.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
	TOTALS		0	145,775		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	234,992	141,922		1.00
	TOTALS		234,992	141,922		
	C - EKG					
1.00	ELECTROCARDIOLOGY	69.00	38,153	0		1.00
2.00		0.00	0	0		2.00
	TOTALS		38,153	0		
	D - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	89,096		1.00
	TOTALS		0	89,096		
	E - OXYGEN/PATIENT SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	157,286		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	157,286		
	F - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,233,676		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	1,233,676		
	H - TELEPHONE					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	238,457		1.00
2.00		0.00	0	0		2.00
5.00		0.00	0	0		5.00
	TOTALS		0	238,457		
	I - STRESS TEST					
1.00	ELECTROCARDIOLOGY	69.00	9,541	5,027		1.00
	TOTALS		9,541	5,027		
	J - MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	842,137		1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,281,403		2.00
	TOTALS		0	2,123,540		
	K - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	107,236		1.00
	TOTALS		0	107,236		
	L - ANESTHESIA BENEFITS					
1.00	ANESTHESIOLOGY	53.00	0	295,361		1.00
	TOTALS		0	295,361		
	M - RADIOLOGY BENEFITS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	123,070		1.00
	TOTALS		0	123,070		
	N - WOUND CARE BENEFITS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,019		1.00
	TOTALS		0	4,019		
500.00	Grand Total: Increases		282,686	4,664,465		500.00

RECLASSIFICATIONS | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/25/2017 2:38 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENTAL EXPENSE						
1.00		0.00	0	0	10		1.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	44,187	0		3.00
4.00	ADMITTING	5.02	0	248	0		4.00
5.00	OPERATION OF PLANT	7.00	0	201	0		5.00
9.00	ADULTS & PEDIATRICS	30.00	0	3,188	0		9.00
10.00	OPERATING ROOM	50.00	0	40,670	0		10.00
11.00	ANESTHESIOLOGY	53.00	0	1,125	0		11.00
13.00	LABORATORY	60.00	0	12	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	15,146	0		14.00
15.00	SENIOR CARE	90.02	0	25,636	0		15.00
17.00	RURAL HEALTH CLINIC	88.00	0	8,913	0		17.00
18.00	RURAL HEALTH CLINIC II	88.01	0	622	0		18.00
20.00	SLEEP LAB	90.03	0	135	0		20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,692	0		21.00
	TOTALS		0	145,775			
	B - CAFETERIA						
1.00	DIETARY	10.00	234,992	141,922	0		1.00
	TOTALS		234,992	141,922			
	C - EKG						
1.00	ADULTS & PEDIATRICS	30.00	19,995	0	0		1.00
2.00	RESPIRATORY THERAPY	65.00	18,158	0	0		2.00
	TOTALS		38,153	0			
	D - PROPERTY INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	89,096	9		1.00
	TOTALS		0	89,096			
	E - OXYGEN/PATIENT SUPPLIES						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	146,952	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	10,334	0		2.00
	TOTALS		0	157,286			
	F - DRUGS						
1.00	PHARMACY	15.00	0	1,204,671	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	29,005	0		2.00
	TOTALS		0	1,233,676			
	H - TELEPHONE						
1.00		0.00	0	0	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	117,637	0		2.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	120,820	0		5.00
	TOTALS		0	238,457			
	I - STRESS TEST						
1.00	CLINIC	90.00	9,541	5,027	0		1.00
	TOTALS		9,541	5,027			
	J - MED SUPPLIES						
1.00	OPERATING ROOM	50.00	0	2,123,540	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	2,123,540			
	K - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	107,236	9		1.00
	TOTALS		0	107,236			
	L - ANESTHESIA BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	295,361	0		1.00
	TOTALS		0	295,361			
	M - RADIOLOGY BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	123,070	0		1.00
	TOTALS		0	123,070			
	N - WOUND CARE BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,019	0		1.00
	TOTALS		0	4,019			
500.00	Grand Total: Decreases		282,686	4,664,465			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 5/25/2017 2:38 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	41,266	362,576	0	362,576	0	1.00
2.00	Land Improvements	1,949,572	322,476	0	322,476	0	2.00
3.00	Buildings and Fixtures	23,706,083	202,050	0	202,050	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	15,647,596	1,129,969	0	1,129,969	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	41,344,517	2,017,071	0	2,017,071	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	41,344,517	2,017,071	0	2,017,071	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	403,842	0	1.00
2.00	Land Improvements	2,272,048	0	2.00
3.00	Buildings and Fixtures	23,908,133	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	16,777,565	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	43,361,588	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	43,361,588	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 5/25/2017 2:38 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	NEW CAP REL COSTS-BLDG & FIXT	756,196	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,550,349	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,306,545	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	NEW CAP REL COSTS-BLDG & FIXT	0	756,196		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,550,349		2.00
3.00	Total (sum of lines 1-2)	0	2,306,545		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/25/2017 2:38 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	NEW CAP REL COSTS-BLDG & FIXT	756,196	0	756,196	0.327848	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,550,349	0	1,550,349	0.672152	0	2.00
3.00	Total (sum of lines 1-2)	2,306,545	0	2,306,545	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	904,628	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,550,349	145,775	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,454,977	145,775	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	904,628	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-154,537	0	0	0	1,541,587	2.00
3.00	Total (sum of lines 1-2)	-154,537	0	0	0	2,446,215	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/25/2017 2:38 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-34,184	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-11,815	OTHER ADMINISTRATIVE AND GENERAL	5.01	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	-2,581,342			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-91,587	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-13,716	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	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	B	-24,362	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-8,925	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** 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		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/25/2017 2:38 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	
33.00	PHYSICIAN RECRUTING	A	-39,187	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.00
34.00	ADVERTISING	A	-77,879	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	34.00
35.00			0		0.00	0	35.00
36.00	ADVERTISING	A	-25,305	RURAL HEALTH CLINIC	88.00	0	36.00
37.00	ADVERTISING	A	-2,075	RURAL HEALTH CLINIC II	88.01	0	37.00
38.00			0		0.00	0	38.00
39.00	ADVERTISING	A	-23,096	PHYSICIANS' PRIVATE OFFICES	192.00	0	39.00
40.00	ANESTHESIA	A	-1,152,491	ANESTHESIOLOGY	53.00	0	40.00
41.00	ANESTHESIA OTHER	A	-295,361	ANESTHESIOLOGY	53.00	0	41.00
42.00	OTHER REVENUE	B	-181,713	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	42.00
43.00	CPR	B	-30,065	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	43.00
44.00	IHA	A	-14,083	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	44.00
45.00	FMC OTHER REVENUE	B	-146,452	RURAL HEALTH CLINIC	88.00	0	45.00
45.01			0		0.00	0	45.01
45.02			0		0.00	0	45.02
45.03	FMC OTHER REVENUE	B	-10,000	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.03
45.04	AHA	A	-2,918	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45.04
45.05			0		0.00	0	45.05
45.06	NRHA	A	-101	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45.06
45.07	RADIOLOGY	A	-541,273	RADIOLOGY-DIAGNOSTIC	54.00	0	45.07
45.08	RADIOLOGY OTHER	A	-123,070	RADIOLOGY-DIAGNOSTIC	54.00	0	45.08
45.09	WOUND CARE	A	-14,566	CHEMO/PAIN	90.01	0	45.09
45.10	WOUND CARE OTHER	A	-4,019	CHEMO/PAIN	90.01	0	45.10
45.11			0		0.00	0	45.11
45.12	MCHC DUES	A	-125	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45.12
45.13	ADVERTISING	A	-3,600	SENIOR CARE	90.02	0	45.13
45.14			0		0.00	0	45.14
45.15	MEANINGFUL USE ACCELERATED PAYMENT	A	-154,537	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	45.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,607,847				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/25/2017 2:38 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	5.01	OTHER ADMINISTRATIVE AND GENERAL	40,095	40,095	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	671,184	671,184	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	46,626	46,626	0	0	0	6.00
7.00	70.00	ELECTROENCEPHALOGRAPHY	1,984	1,984	0	0	0	7.00
8.00	90.00	CLINIC	22,910	13,910	9,000	0	0	8.00
9.00	90.01	CHEMO/PAIN	330,792	302,792	28,000	0	0	9.00
10.00	90.02	SENIOR CARE	34,042	0	34,042	0	0	10.00
11.00	90.03	SLEEP LAB	39,803	29,803	10,000	0	0	11.00
12.00	91.00	EMERGENCY	1,873,559	1,474,948	398,611	0	0	12.00
200.00			3,060,995	2,581,342	479,653		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	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	90.01	CHEMO/PAIN	0	0	0	0	0	9.00
10.00	90.02	SENIOR CARE	0	0	0	0	0	10.00
11.00	90.03	SLEEP LAB	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	0	0	0	0	0	12.00
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	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	40,095		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	671,184		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	46,626		6.00
7.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	1,984		7.00
8.00	90.00	CLINIC	0	0	0	13,910		8.00
9.00	90.01	CHEMO/PAIN	0	0	0	302,792		9.00
10.00	90.02	SENIOR CARE	0	0	0	0		10.00
11.00	90.03	SLEEP LAB	0	0	0	29,803		11.00
12.00	91.00	EMERGENCY	0	0	0	1,474,948		12.00
200.00			0	0	0	2,581,342		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/25/2017 2:38 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	904,628	904,628				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,541,587		1,541,587			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,769,589	6,832	11,643	4,788,064		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	4,062,005	150,592	256,630	434,856	4,904,083	5.01
5.02	00560	ADMITTING	1,004,797	24,248	41,321	137,281	1,207,647	5.02
7.00	00700	OPERATION OF PLANT	1,244,967	87,417	148,968	97,125	1,578,477	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	156,601	7,156	12,195	0	175,952	8.00
9.00	00900	HOUSEKEEPING	271,728	5,034	8,578	44,616	329,956	9.00
10.00	01000	DIETARY	272,045	22,611	38,532	38,175	371,363	10.00
11.00	01100	CAFETERIA	285,327	10,289	17,533	52,890	366,039	11.00
13.00	01300	NURSING ADMINISTRATION	1,151,494	10,171	17,332	230,234	1,409,231	13.00
15.00	01500	PHARMACY	300,183	6,419	10,939	58,534	376,075	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	546,905	16,443	28,020	105,615	696,983	16.00
17.00	01700	SOCIAL SERVICE	74,701	1,150	1,959	12,200	90,010	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,713,699	103,226	175,908	450,312	2,443,145	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,749,403	74,843	127,541	298,026	2,249,813	50.00
53.00	05300	ANESTHESIOLOGY	114,989	877	1,495	0	117,361	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,667,174	54,281	92,500	204,569	2,018,524	54.00
60.00	06000	LABORATORY	1,817,070	22,619	38,545	176,124	2,054,358	60.00
65.00	06500	RESPIRATORY THERAPY	492,409	2,808	4,785	95,255	595,257	65.00
66.00	06600	PHYSICAL THERAPY	1,226,029	32,451	55,299	240,599	1,554,378	66.00
69.00	06900	ELECTROCARDIOLOGY	53,547	3,862	6,581	10,735	74,725	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	192	2,270	3,868	0	6,330	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	999,423	0	0	0	999,423	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,281,403	0	0	0	1,281,403	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,209,314	0	0	0	1,209,314	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,228,706	135,389	230,717	846,304	5,441,116	88.00
88.01	08801	RURAL HEALTH CLINIC II	322,739	11,055	18,839	49,478	402,111	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	113,329	4,533	7,724	18,756	144,342	90.00
90.01	04951	CHEMO/PAIN	801,364	9,109	15,524	202,591	1,028,588	90.01
90.02	09002	SENIOR CARE	434,571	11,792	20,095	333	466,791	90.02
90.03	09003	SLEEP LAB	81,084	958	1,633	12,956	96,631	90.03
91.00	09100	EMERGENCY	1,540,216	37,985	64,732	218,973	1,861,906	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)	36,433,218	856,420	1,459,436	4,036,537	35,551,332	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,150,018	32,399	55,211	751,527	4,989,155	192.00
192.01	19202	OCCUPATIONAL MEDICINE	11,820	15,809	26,940	0	54,569	192.01
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)	40,595,056	904,628	1,541,587	4,788,064	40,595,056	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/25/2017 2:38 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	4,904,083					5.01
5.02	00560	ADMITTING	165,936	1,373,583				5.02
7.00	00700	OPERATION OF PLANT	216,889	0	1,795,366			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	24,177	0	20,216	220,345		8.00
9.00	00900	HOUSEKEEPING	45,337	0	14,220	0	389,513	9.00
10.00	01000	DIETARY	51,027	0	63,876	0	14,129	10.00
11.00	01100	CAFETERIA	50,295	0	29,065	0	6,429	11.00
13.00	01300	NURSING ADMINISTRATION	193,634	0	28,732	0	6,355	13.00
15.00	01500	PHARMACY	51,674	0	18,134	0	4,011	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	95,768	0	46,450	0	10,275	16.00
17.00	01700	SOCIAL SERVICE	12,368	0	3,248	0	718	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	335,698	184,369	291,607	220,345	64,503	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	309,133	169,775	211,429	0	46,768	50.00
53.00	05300	ANESTHESIOLOGY	16,126	8,856	2,478	0	548	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	277,353	152,322	153,341	0	33,919	54.00
60.00	06000	LABORATORY	282,277	155,026	63,897	0	14,134	60.00
65.00	06500	RESPIRATORY THERAPY	81,791	44,919	7,932	0	1,755	65.00
66.00	06600	PHYSICAL THERAPY	213,578	117,296	91,671	0	20,277	66.00
69.00	06900	ELECTROCARDIOLOGY	10,268	5,639	10,910	0	2,413	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	870	478	6,413	0	1,418	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	137,325	75,418	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	176,070	96,697	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	166,165	91,257	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	747,630	0	382,468	0	84,601	88.00
88.01	08801	RURAL HEALTH CLINIC II	55,252	0	31,230	0	6,908	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	19,833	10,892	12,804	0	2,832	90.00
90.01	04951	CHEMO/PAIN	141,332	77,619	25,734	0	5,692	90.01
90.02	09002	SENIOR CARE	64,139	35,225	33,312	0	7,369	90.02
90.03	09003	SLEEP LAB	13,277	7,292	2,707	0	599	90.03
91.00	09100	EMERGENCY	255,833	140,503	107,307	0	23,736	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)	4,211,055	1,373,583	1,659,181	220,345	359,389	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	685,530	0	91,526	0	20,245	192.00
192.01	19202	OCCUPATIONAL MEDICINE	7,498	0	44,659	0	9,879	192.01
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)	4,904,083	1,373,583	1,795,366	220,345	389,513	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/25/2017 2:38 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
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	500,395					10.00
11.00	01100	CAFETERIA	0	451,828				11.00
13.00	01300	NURSING ADMINISTRATION	0	26,117	1,664,069			13.00
15.00	01500	PHARMACY	0	6,640	0	456,534		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,980	0	0	861,456	16.00
17.00	01700	SOCIAL SERVICE	0	1,384	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	500,395	51,081	580,236	0	27,837	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	33,806	489,816	568	108,906	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	17,263	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,205	0	1,700	214,700	54.00
60.00	06000	LABORATORY	0	19,979	0	6	154,173	60.00
65.00	06500	RESPIRATORY THERAPY	0	10,805	0	933	5,681	65.00
66.00	06600	PHYSICAL THERAPY	0	27,292	0	265	93,404	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,218	0	0	12,400	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	29	130	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	76,449	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	442,715	63,649	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	96,004	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	5,612	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	2,128	0	86	2,524	90.00
90.01	04951	CHEMO/PAIN	0	22,981	235,699	4,734	10,634	90.01
90.02	09002	SENIOR CARE	0	38	578	0	6,371	90.02
90.03	09003	SLEEP LAB	0	1,470	0	0	4,232	90.03
91.00	09100	EMERGENCY	0	24,839	357,740	1,154	63,103	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)	500,395	366,579	1,664,069	452,190	861,456	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	85,249	0	0	0	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	0	0	4,344	0	192.01
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)	500,395	451,828	1,664,069	456,534	861,456	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/25/2017 2:38 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
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
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	107,728					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	107,728	4,806,944	0	4,806,944		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,620,014	0	3,620,014		50.00
53.00	05300	ANESTHESIOLOGY	0	162,632	0	162,632		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,875,064	0	2,875,064		54.00
60.00	06000	LABORATORY	0	2,743,850	0	2,743,850		60.00
65.00	06500	RESPIRATORY THERAPY	0	749,073	0	749,073		65.00
66.00	06600	PHYSICAL THERAPY	0	2,118,161	0	2,118,161		66.00
69.00	06900	ELECTROCARDIOLOGY	0	117,573	0	117,573		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	15,668	0	15,668		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,288,615	0	1,288,615		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,554,170	0	1,554,170		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,973,100	0	1,973,100		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,751,819	0	6,751,819		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	501,113	0	501,113		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0		88.02
90.00	09000	CLINIC	0	195,441	0	195,441		90.00
90.01	04951	CHEMO/PAIN	0	1,553,013	0	1,553,013		90.01
90.02	09002	SENIOR CARE	0	613,823	0	613,823		90.02
90.03	09003	SLEEP LAB	0	126,208	0	126,208		90.03
91.00	09100	EMERGENCY	0	2,836,121	0	2,836,121		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)	107,728	34,602,402	0	34,602,402		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,871,705	0	5,871,705		192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	120,949	0	120,949		192.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	107,728	40,595,056	0	40,595,056		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/25/2017 2:38 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,832	11,643	18,475	18,475	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	0	150,592	256,630	407,222	1,677	5.01
5.02	00560	ADMITTING	0	24,248	41,321	65,569	529	5.02
7.00	00700	OPERATION OF PLANT	0	87,417	148,968	236,385	375	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,156	12,195	19,351	0	8.00
9.00	00900	HOUSEKEEPING	0	5,034	8,578	13,612	172	9.00
10.00	01000	DIETARY	0	22,611	38,532	61,143	147	10.00
11.00	01100	CAFETERIA	0	10,289	17,533	27,822	204	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,171	17,332	27,503	888	13.00
15.00	01500	PHARMACY	0	6,419	10,939	17,358	226	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,443	28,020	44,463	407	16.00
17.00	01700	SOCIAL SERVICE	0	1,150	1,959	3,109	47	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	103,226	175,908	279,134	1,737	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	74,843	127,541	202,384	1,149	50.00
53.00	05300	ANESTHESIOLOGY	0	877	1,495	2,372	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,281	92,500	146,781	789	54.00
60.00	06000	LABORATORY	0	22,619	38,545	61,164	679	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,808	4,785	7,593	367	65.00
66.00	06600	PHYSICAL THERAPY	0	32,451	55,299	87,750	928	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,862	6,581	10,443	41	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,270	3,868	6,138	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	135,389	230,717	366,106	3,276	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	11,055	18,839	29,894	191	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	4,533	7,724	12,257	72	90.00
90.01	04951	CHEMO/PAIN	0	9,109	15,524	24,633	781	90.01
90.02	09002	SENIOR CARE	0	11,792	20,095	31,887	1	90.02
90.03	09003	SLEEP LAB	0	958	1,633	2,591	50	90.03
91.00	09100	EMERGENCY	0	37,985	64,732	102,717	844	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	856,420	1,459,436	2,315,856	15,577	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	32,399	55,211	87,610	2,898	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	15,809	26,940	42,749	0	192.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	904,628	1,541,587	2,446,215	18,475	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/25/2017 2:38 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	408,899					5.01
5.02	00560	ADMITTING	13,836	79,934				5.02
7.00	00700	OPERATION OF PLANT	18,085	0	254,845			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,016	0	2,870	24,237		8.00
9.00	00900	HOUSEKEEPING	3,780	0	2,018	0	19,582	9.00
10.00	01000	DIETARY	4,255	0	9,067	0	710	10.00
11.00	01100	CAFETERIA	4,194	0	4,126	0	323	11.00
13.00	01300	NURSING ADMINISTRATION	16,146	0	4,078	0	320	13.00
15.00	01500	PHARMACY	4,309	0	2,574	0	202	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,985	0	6,593	0	517	16.00
17.00	01700	SOCIAL SERVICE	1,031	0	461	0	36	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,991	10,735	41,393	24,237	3,243	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,776	9,879	30,011	0	2,351	50.00
53.00	05300	ANESTHESIOLOGY	1,345	515	352	0	28	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,126	8,863	21,766	0	1,705	54.00
60.00	06000	LABORATORY	23,537	9,021	9,070	0	711	60.00
65.00	06500	RESPIRATORY THERAPY	6,820	2,614	1,126	0	88	65.00
66.00	06600	PHYSICAL THERAPY	17,809	6,825	13,012	0	1,019	66.00
69.00	06900	ELECTROCARDIOLOGY	856	328	1,549	0	121	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	73	28	910	0	71	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,450	4,388	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,681	5,627	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,855	5,310	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	62,324	0	54,289	0	4,254	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,607	0	4,433	0	347	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	1,654	634	1,818	0	142	90.00
90.01	04951	CHEMO/PAIN	11,785	4,517	3,653	0	286	90.01
90.02	09002	SENIOR CARE	5,348	2,050	4,729	0	370	90.02
90.03	09003	SLEEP LAB	1,107	424	384	0	30	90.03
91.00	09100	EMERGENCY	21,332	8,176	15,232	0	1,193	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)	351,113	79,934	235,514	24,237	18,067	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	57,161	0	12,992	0	1,018	192.00
192.01	19202	OCCUPATIONAL MEDICINE	625	0	6,339	0	497	192.01
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)	408,899	79,934	254,845	24,237	19,582	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/25/2017 2:38 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
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	75,322					10.00
11.00	01100	CAFETERIA	0	36,669				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,120	51,055			13.00
15.00	01500	PHARMACY	0	539	0	25,208		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	972	0	0	60,937	16.00
17.00	01700	SOCIAL SERVICE	0	112	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	75,322	4,146	17,801	0	1,970	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,744	15,028	31	7,706	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,221	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,883	0	94	15,177	54.00
60.00	06000	LABORATORY	0	1,621	0	0	10,908	60.00
65.00	06500	RESPIRATORY THERAPY	0	877	0	52	402	65.00
66.00	06600	PHYSICAL THERAPY	0	2,215	0	15	6,609	66.00
69.00	06900	ELECTROCARDIOLOGY	0	99	0	0	877	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2	9	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	5,409	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	24,444	4,503	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,791	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	455	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	173	0	5	179	90.00
90.01	04951	CHEMO/PAIN	0	1,865	7,232	261	752	90.01
90.02	09002	SENIOR CARE	0	3	18	0	451	90.02
90.03	09003	SLEEP LAB	0	119	0	0	299	90.03
91.00	09100	EMERGENCY	0	2,016	10,976	64	4,465	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)	75,322	29,750	51,055	24,968	60,937	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,919	0	0	0	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	0	0	240	0	192.01
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)	75,322	36,669	51,055	25,208	60,937	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/25/2017 2:38 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
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
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	4,796					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,796	492,505	0	492,505		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	297,059	0	297,059		50.00
53.00	05300	ANESTHESIOLOGY	0	5,833	0	5,833		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	220,184	0	220,184		54.00
60.00	06000	LABORATORY	0	116,711	0	116,711		60.00
65.00	06500	RESPIRATORY THERAPY	0	19,939	0	19,939		65.00
66.00	06600	PHYSICAL THERAPY	0	136,182	0	136,182		66.00
69.00	06900	ELECTROCARDIOLOGY	0	14,314	0	14,314		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,231	0	7,231		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,247	0	21,247		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	20,308	0	20,308		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	48,112	0	48,112		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	498,040	0	498,040		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	39,927	0	39,927		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0		88.02
90.00	09000	CLINIC	0	16,934	0	16,934		90.00
90.01	04951	CHEMO/PAIN	0	55,765	0	55,765		90.01
90.02	09002	SENIOR CARE	0	44,857	0	44,857		90.02
90.03	09003	SLEEP LAB	0	5,004	0	5,004		90.03
91.00	09100	EMERGENCY	0	167,015	0	167,015		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)	4,796	2,227,167	0	2,227,167		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	168,598	0	168,598		192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	50,450	0	50,450		192.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	4,796	2,446,215	0	2,446,215		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/25/2017 2:38 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	122,743					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		122,743				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	927	927	21,273,464			4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	20,433	20,433	1,932,074	-4,904,083	35,690,973	5.01
5.02	00560	ADMITTING	3,290	3,290	609,943	0	1,207,647	5.02
7.00	00700	OPERATION OF PLANT	11,861	11,861	431,529	0	1,578,477	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	971	971	0	0	175,952	8.00
9.00	00900	HOUSEKEEPING	683	683	198,231	0	329,956	9.00
10.00	01000	DIETARY	3,068	3,068	169,611	0	371,363	10.00
11.00	01100	CAFETERIA	1,396	1,396	234,992	0	366,039	11.00
13.00	01300	NURSING ADMINISTRATION	1,380	1,380	1,022,935	0	1,409,231	13.00
15.00	01500	PHARMACY	871	871	260,069	0	376,075	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,231	2,231	469,250	0	696,983	16.00
17.00	01700	SOCIAL SERVICE	156	156	54,207	0	90,010	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,006	14,006	2,000,746	0	2,443,145	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,155	10,155	1,324,135	0	2,249,813	50.00
53.00	05300	ANESTHESIOLOGY	119	119	0	0	117,361	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,365	7,365	908,904	0	2,018,524	54.00
60.00	06000	LABORATORY	3,069	3,069	782,522	0	2,054,358	60.00
65.00	06500	RESPIRATORY THERAPY	381	381	423,219	0	595,257	65.00
66.00	06600	PHYSICAL THERAPY	4,403	4,403	1,068,985	0	1,554,378	66.00
69.00	06900	ELECTROCARDIOLOGY	524	524	47,694	0	74,725	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	308	308	0	0	6,330	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	999,423	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,281,403	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,209,314	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	18,370	18,370	3,760,142	0	5,441,116	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,500	1,500	219,830	0	402,111	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	615	615	83,332	0	144,342	90.00
90.01	04951	CHEMO/PAIN	1,236	1,236	900,117	0	1,028,588	90.01
90.02	09002	SENIOR CARE	1,600	1,600	1,480	0	466,791	90.02
90.03	09003	SLEEP LAB	130	130	57,566	0	96,631	90.03
91.00	09100	EMERGENCY	5,154	5,154	972,900	0	1,861,906	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)	116,202	116,202	17,934,413	-4,904,083	30,647,249	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,396	4,396	3,339,051	0	4,989,155	192.00
192.01	19202	OCCUPATIONAL MEDICINE	2,145	2,145	0	0	54,569	192.01
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)	904,628	1,541,587	4,788,064		4,904,083	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.370098	12.559470	0.225072		0.137404	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			18,475		408,899	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000868		0.011457	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/25/2017 2:38 pm

		Cost Center Description	ADMITTING (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			5.02	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING	18,202,289					5.02
7.00	00700	OPERATION OF PLANT	0	86,232				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	971	100			8.00
9.00	00900	HOUSEKEEPING	0	683	0	84,578		9.00
10.00	01000	DIETARY	0	3,068	0	3,068	100	10.00
11.00	01100	CAFETERIA	0	1,396	0	1,396	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,380	0	1,380	0	13.00
15.00	01500	PHARMACY	0	871	0	871	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,231	0	2,231	0	16.00
17.00	01700	SOCIAL SERVICE	0	156	0	156	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,443,145	14,006	100	14,006	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,249,813	10,155	0	10,155	0	50.00
53.00	05300	ANESTHESIOLOGY	117,361	119	0	119	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,018,524	7,365	0	7,365	0	54.00
60.00	06000	LABORATORY	2,054,358	3,069	0	3,069	0	60.00
65.00	06500	RESPIRATORY THERAPY	595,257	381	0	381	0	65.00
66.00	06600	PHYSICAL THERAPY	1,554,378	4,403	0	4,403	0	66.00
69.00	06900	ELECTROCARDIOLOGY	74,725	524	0	524	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,330	308	0	308	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	999,423	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,281,403	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,209,314	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	18,370	0	18,370	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,500	0	1,500	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	144,342	615	0	615	0	90.00
90.01	04951	CHEMO/PAIN	1,028,588	1,236	0	1,236	0	90.01
90.02	09002	SENIOR CARE	466,791	1,600	0	1,600	0	90.02
90.03	09003	SLEEP LAB	96,631	130	0	130	0	90.03
91.00	09100	EMERGENCY	1,861,906	5,154	0	5,154	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)	18,202,289	79,691	100	78,037	100	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,396	0	4,396	0	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	2,145	0	2,145	0	192.01
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)	1,373,583	1,795,366	220,345	389,513	500,395	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.075462	20.820183	2,203.450000	4.605370	5,003.950000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	79,934	254,845	24,237	19,582	75,322	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.004391	2.955341	242.370000	0.231526	753.220000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/25/2017 2:38 pm

		Cost Center Description	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NRSNG SALARIES)	PHARMACY (COST REQU.)	MEDICAL RECORDS & LIBRARY (GROSS REV)	SOCIAL SERVICE (PAT DAYS)	
			11.00	13.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
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	17,697,084					11.00
13.00	01300	NURSING ADMINISTRATION	1,022,935	4,264,628				13.00
15.00	01500	PHARMACY	260,069	0	1,242,273			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	469,250	0	0	73,972,000		16.00
17.00	01700	SOCIAL SERVICE	54,207	0	0	0	100	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,000,746	1,487,017	0	2,390,222	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,324,135	1,255,285	1,545	9,351,374	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,482,302	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	908,904	0	4,625	18,437,237	0	54.00
60.00	06000	LABORATORY	782,522	0	17	13,238,299	0	60.00
65.00	06500	RESPIRATORY THERAPY	423,219	0	2,540	487,833	0	65.00
66.00	06600	PHYSICAL THERAPY	1,068,985	0	721	8,020,293	0	66.00
69.00	06900	ELECTROCARDIOLOGY	47,694	0	0	1,064,772	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	79	11,125	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,564,403	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,204,671	5,465,351	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,760,142	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	219,830	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	83,332	0	233	216,732	0	90.00
90.01	04951	CHEMO/PAIN	900,117	604,041	12,881	913,144	0	90.01
90.02	09002	SENIOR CARE	1,480	1,480	0	547,086	0	90.02
90.03	09003	SLEEP LAB	57,566	0	0	363,429	0	90.03
91.00	09100	EMERGENCY	972,900	916,805	3,141	5,418,398	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)	14,358,033	4,264,628	1,230,453	73,972,000	100	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,339,051	0	0	0	0	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	0	11,820	0	0	192.01
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)	451,828	1,664,069	456,534	861,456	107,728	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.025531	0.390203	0.367499	0.011646	1,077.280000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	36,669	51,055	25,208	60,937	4,796	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002072	0.011972	0.020292	0.000824	47.960000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/25/2017 2:38 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	4,806,944		4,806,944	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,620,014		3,620,014	0	0	50.00
53.00	05300	ANESTHESIOLOGY	162,632		162,632	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,875,064		2,875,064	0	0	54.00
60.00	06000	LABORATORY	2,743,850		2,743,850	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	749,073	0	749,073	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,118,161	0	2,118,161	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	117,573		117,573	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,668		15,668	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,288,615		1,288,615	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,554,170		1,554,170	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,973,100		1,973,100	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,751,819		6,751,819	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	501,113		501,113	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0		0	0	0	88.02
90.00	09000	CLINIC	195,441		195,441	0	0	90.00
90.01	04951	CHEMO/PAIN	1,553,013		1,553,013	0	0	90.01
90.02	09002	SENIOR CARE	613,823		613,823	0	0	90.02
90.03	09003	SLEEP LAB	126,208		126,208	0	0	90.03
91.00	09100	EMERGENCY	2,836,121		2,836,121	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	381,071		381,071		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	34,983,473	0	34,983,473	0	0	200.00
201.00		Less Observation Beds	381,071		381,071		0	201.00
202.00		Total (see instructions)	34,602,402	0	34,602,402	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/25/2017 2:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,111,736		2,111,736			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,479,551	6,871,823	9,351,374	0.387110	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	433,717	1,048,585	1,482,302	0.109716	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	670,066	17,767,172	18,437,238	0.155938	0.000000	54.00
60.00	06000	LABORATORY	778,960	12,459,338	13,238,298	0.207266	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	251,257	236,576	487,833	1.535511	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,072,884	6,947,409	8,020,293	0.264100	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	28,895	1,035,877	1,064,772	0.110421	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,125	11,125	1.408360	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,473,719	2,486,307	3,960,026	0.325406	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,963,237	641,141	2,604,378	0.596753	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,296,798	4,168,553	5,465,351	0.361020	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	10,525,266	10,525,266			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	161,261	161,261			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0			88.02
90.00	09000	CLINIC	0	216,732	216,732	0.901763	0.000000	90.00
90.01	04951	CHEMO/PAIN	96	913,048	913,144	1.700732	0.000000	90.01
90.02	09002	SENIOR CARE	0	547,086	547,086	1.121986	0.000000	90.02
90.03	09003	SLEEP LAB	0	363,429	363,429	0.347270	0.000000	90.03
91.00	09100	EMERGENCY	87,184	5,331,215	5,418,399	0.523424	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,372	274,114	278,486	1.368367	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,652,472	72,006,057	84,658,529			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,652,472	72,006,057	84,658,529			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/25/2017 2:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.000000
53.00	05300	ANESTHESIOLOGY	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000
60.00	06000	LABORATORY	0.000000
65.00	06500	RESPIRATORY THERAPY	0.000000
66.00	06600	PHYSICAL THERAPY	0.000000
69.00	06900	ELECTROCARDIOLOGY	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000
		OUTPATIENT SERVICE COST CENTERS	
88.00	08800	RURAL HEALTH CLINIC	
88.01	08801	RURAL HEALTH CLINIC II	
88.02	08802	RURAL HEALTH CLINIC III	
90.00	09000	CLINIC	0.000000
90.01	04951	CHEMO/PAIN	0.000000
90.02	09002	SENIOR CARE	0.000000
90.03	09003	SLEEP LAB	0.000000
91.00	09100	EMERGENCY	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000
		SPECIAL PURPOSE COST CENTERS	
113.00	11300	INTEREST EXPENSE	
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/25/2017 2:38 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,806,944		4,806,944	0	4,806,944	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,620,014		3,620,014	0	3,620,014	50.00
53.00	05300	ANESTHESIOLOGY	162,632		162,632	0	162,632	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,875,064		2,875,064	0	2,875,064	54.00
60.00	06000	LABORATORY	2,743,850		2,743,850	0	2,743,850	60.00
65.00	06500	RESPIRATORY THERAPY	749,073	0	749,073	0	749,073	65.00
66.00	06600	PHYSICAL THERAPY	2,118,161	0	2,118,161	0	2,118,161	66.00
69.00	06900	ELECTROCARDIOLOGY	117,573		117,573	0	117,573	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,668		15,668	0	15,668	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,288,615		1,288,615	0	1,288,615	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,554,170		1,554,170	0	1,554,170	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,973,100		1,973,100	0	1,973,100	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,751,819		6,751,819	0	6,751,819	88.00
88.01	08801	RURAL HEALTH CLINIC II	501,113		501,113	0	501,113	88.01
88.02	08802	RURAL HEALTH CLINIC III	0		0	0	0	88.02
90.00	09000	CLINIC	195,441		195,441	0	195,441	90.00
90.01	04951	CHEMO/PAIN	1,553,013		1,553,013	0	1,553,013	90.01
90.02	09002	SENIOR CARE	613,823		613,823	0	613,823	90.02
90.03	09003	SLEEP LAB	126,208		126,208	0	126,208	90.03
91.00	09100	EMERGENCY	2,836,121		2,836,121	0	2,836,121	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	381,071		381,071		381,071	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	34,983,473	0	34,983,473	0	34,983,473	200.00
201.00		Less Observation Beds	381,071		381,071		381,071	201.00
202.00		Total (see instructions)	34,602,402	0	34,602,402	0	34,602,402	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/25/2017 2:38 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,111,736		2,111,736			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,479,551	6,871,823	9,351,374	0.387110	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	433,717	1,048,585	1,482,302	0.109716	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	670,066	17,767,172	18,437,238	0.155938	0.000000	54.00
60.00	06000	LABORATORY	778,960	12,459,338	13,238,298	0.207266	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	251,257	236,576	487,833	1.535511	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,072,884	6,947,409	8,020,293	0.264100	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	28,895	1,035,877	1,064,772	0.110421	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,125	11,125	1.408360	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,473,719	2,486,307	3,960,026	0.325406	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,963,237	641,141	2,604,378	0.596753	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,296,798	4,168,553	5,465,351	0.361020	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	10,525,266	10,525,266	0.641487	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	161,261	161,261	3.107466	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0.000000	0.000000	88.02
90.00	09000	CLINIC	0	216,732	216,732	0.901763	0.000000	90.00
90.01	04951	CHEMO/PAIN	96	913,048	913,144	1.700732	0.000000	90.01
90.02	09002	SENIOR CARE	0	547,086	547,086	1.121986	0.000000	90.02
90.03	09003	SLEEP LAB	0	363,429	363,429	0.347270	0.000000	90.03
91.00	09100	EMERGENCY	87,184	5,331,215	5,418,399	0.523424	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,372	274,114	278,486	1.368367	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,652,472	72,006,057	84,658,529			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,652,472	72,006,057	84,658,529			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/25/2017 2:38 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	88.02
90.00	09000	CLINIC	0.000000	90.00
90.01	04951	CHEMO/PAIN	0.000000	90.01
90.02	09002	SENIOR CARE	0.000000	90.02
90.03	09003	SLEEP LAB	0.000000	90.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	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: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/25/2017 2:38 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	297,059	9,351,374	0.031766	1,135,615	36,074	50.00
53.00	05300	ANESTHESIOLOGY	5,833	1,482,302	0.003935	190,769	751	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	220,184	18,437,238	0.011942	376,670	4,498	54.00
60.00	06000	LABORATORY	116,711	13,238,298	0.008816	411,340	3,626	60.00
65.00	06500	RESPIRATORY THERAPY	19,939	487,833	0.040873	118,330	4,837	65.00
66.00	06600	PHYSICAL THERAPY	136,182	8,020,293	0.016980	308,860	5,244	66.00
69.00	06900	ELECTROCARDIOLOGY	14,314	1,064,772	0.013443	16,314	219	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,231	11,125	0.649978	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,247	3,960,026	0.005365	694,339	3,725	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	20,308	2,604,378	0.007798	1,010,897	7,883	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,112	5,465,351	0.008803	625,976	5,510	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	498,040	10,525,266	0.047319	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	39,927	161,261	0.247592	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0.000000	0	0	88.02
90.00	09000	CLINIC	16,934	216,732	0.078133	0	0	90.00
90.01	04951	CHEMO/PAIN	55,765	913,144	0.061069	96	6	90.01
90.02	09002	SENIOR CARE	44,857	547,086	0.081993	0	0	90.02
90.03	09003	SLEEP LAB	5,004	363,429	0.013769	0	0	90.03
91.00	09100	EMERGENCY	167,015	5,418,399	0.030824	8,046	248	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	39,043	278,486	0.140197	1,091	153	92.00
200.00		Total (lines 50-199)	1,773,705	82,546,793		4,898,343	72,774	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/25/2017 2:38 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	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	CHEMO/PAIN	0	0	0	0	0	90.01
90.02	09002	SENIOR CARE	0	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0	0	0	0	0	90.03
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: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/25/2017 2:38 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	9,351,374	0.000000	0.000000	1,135,615	50.00
53.00	05300	ANESTHESIOLOGY	0	1,482,302	0.000000	0.000000	190,769	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,437,238	0.000000	0.000000	376,670	54.00
60.00	06000	LABORATORY	0	13,238,298	0.000000	0.000000	411,340	60.00
65.00	06500	RESPIRATORY THERAPY	0	487,833	0.000000	0.000000	118,330	65.00
66.00	06600	PHYSICAL THERAPY	0	8,020,293	0.000000	0.000000	308,860	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,064,772	0.000000	0.000000	16,314	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,125	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,960,026	0.000000	0.000000	694,339	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,604,378	0.000000	0.000000	1,010,897	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,465,351	0.000000	0.000000	625,976	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	10,525,266	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	161,261	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0.000000	0.000000	0	88.02
90.00	09000	CLINIC	0	216,732	0.000000	0.000000	0	90.00
90.01	04951	CHEMO/PAIN	0	913,144	0.000000	0.000000	96	90.01
90.02	09002	SENIOR CARE	0	547,086	0.000000	0.000000	0	90.02
90.03	09003	SLEEP LAB	0	363,429	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	5,418,399	0.000000	0.000000	8,046	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	278,486	0.000000	0.000000	1,091	92.00
200.00		Total (lines 50-199)	0	82,546,793			4,898,343	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/25/2017 2:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
90.00	09000	CLINIC	0	0	0		90.00
90.01	04951	CHEMO/PAIN	0	0	0		90.01
90.02	09002	SENIOR CARE	0	0	0		90.02
90.03	09003	SLEEP LAB	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/25/2017 2:38 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	0.387110	0	1,852,161	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.109716	0	289,398	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.155938	0	5,321,565	0	0	54.00
60.00	06000	LABORATORY	0.207266	0	4,304,736	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.535511	0	78,264	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.264100	0	2,288,534	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110421	0	339,916	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.408360	0	2,928	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.325406	0	745,049	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.596753	0	156,642	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.361020	0	1,368,535	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
90.00	09000	CLINIC	0.901763	0	75,264	0	0	90.00
90.01	04951	CHEMO/PAIN	1.700732	0	296,496	0	0	90.01
90.02	09002	SENIOR CARE	1.121986	0	526,037	0	0	90.02
90.03	09003	SLEEP LAB	0.347270	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.523424	0	1,387,768	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.368367	0	76,385	0	0	92.00
200.00		Subtotal (see instructions)		0	19,109,678	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	19,109,678	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/25/2017 2:38 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	716,990	0		50.00
53.00	05300	ANESTHESIOLOGY	31,752	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	829,834	0		54.00
60.00	06000	LABORATORY	892,225	0		60.00
65.00	06500	RESPIRATORY THERAPY	120,175	0		65.00
66.00	06600	PHYSICAL THERAPY	604,402	0		66.00
69.00	06900	ELECTROCARDIOLOGY	37,534	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,124	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	242,443	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	93,477	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	494,069	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	67,870	0		90.00
90.01	04951	CHEMO/PAIN	504,260	0		90.01
90.02	09002	SENIOR CARE	590,206	0		90.02
90.03	09003	SLEEP LAB	0	0		90.03
91.00	09100	EMERGENCY	726,391	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	104,523	0		92.00
200.00		Subtotal (see instructions)	6,060,275	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	6,060,275	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1320 | Component CCN: 14-Z320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/25/2017 2:38 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	0.387110	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.109716	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.155938	0	0	0	0	54.00
60.00	06000	LABORATORY	0.207266	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.535511	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.264100	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110421	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.408360	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.325406	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.596753	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.361020	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
90.00	09000	CLINIC	0.901763	0	0	0	0	90.00
90.01	04951	CHEMO/PAIN	1.700732	0	0	0	0	90.01
90.02	09002	SENIOR CARE	1.121986	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0.347270	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.523424	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.368367	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: 14-1320 | Component CCN: 14-Z320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 5/25/2017 2:38 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
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	0	0		90.00
90.01	04951	CHEMO/PAIN	0	0		90.01
90.02	09002	SENIOR CARE	0	0		90.02
90.03	09003	SLEEP LAB	0	0		90.03
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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/25/2017 2:38 pm

Title XIX | 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	0.387110	0	0	1	0	50.00
53.00	05300	ANESTHESIOLOGY	0.109716	0	0	1	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.155938	0	0	1	0	54.00
60.00	06000	LABORATORY	0.207266	0	0	1	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.535511	0	0	1	0	65.00
66.00	06600	PHYSICAL THERAPY	0.264100	0	0	1	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110421	0	0	1	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.408360	0	0	1	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.325406	0	0	1	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.596753	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.361020	0	0	1	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.641487				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3.107466				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
90.00	09000	CLINIC	0.901763	0	0	1	0	90.00
90.01	04951	CHEMO/PAIN	1.700732	0	0	1	0	90.01
90.02	09002	SENIOR CARE	1.121986	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0.347270	0	0	1	0	90.03
91.00	09100	EMERGENCY	0.523424	0	0	1	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.368367	0	0	1	0	92.00
200.00		Subtotal (see instructions)		0	0	15	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	15	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/25/2017 2:38 pm

Title XIX | 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	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	88.02
90.00	09000	CLINIC	0	1	90.00
90.01	04951	CHEMO/PAIN	0	2	90.01
90.02	09002	SENIOR CARE	0	0	90.02
90.03	09003	SLEEP LAB	0	0	90.03
91.00	09100	EMERGENCY	0	1	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1	92.00
200.00		Subtotal (see instructions)	0	8	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	8	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 2:38 pm

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,943	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,836	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)	1,634	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	553	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	2,554	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)	1,057	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)	553	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	117.51	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	117.51	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,806,944	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)	300,121	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)	1,343,350	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,463,594	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,463,594	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,886.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,994,020	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)	1,994,020	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 2:38 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)	1,930,655	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,924,675	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)	1,043,229	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)	1,043,229	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)	202	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,886.49	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	381,071	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 2:38 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	492,505	4,806,944	0.102457	381,071	39,043	90.00
91.00	Nursing School cost	0	4,806,944	0.000000	381,071	0	91.00
92.00	Allied health cost	0	4,806,944	0.000000	381,071	0	92.00
93.00	All other Medical Education	0	4,806,944	0.000000	381,071	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 2:38 pm

Title XIX | 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)	4,943	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,836	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)	1,634	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	553	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	2,554	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)	193	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	117.51	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	117.51	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,806,944	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)	300,121	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)	1,343,350	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,463,594	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,463,594	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,886.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	364,093	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)	364,093	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 2:38 pm

Title XIX | 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)	4	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	364,097	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)	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)	202	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,886.49	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	381,071	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 2:38 pm

Title XIX | 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	492,505	4,806,944	0.102457	381,071	39,043	90.00
91.00	Nursing School cost	0	4,806,944	0.000000	381,071	0	91.00
92.00	Allied health cost	0	4,806,944	0.000000	381,071	0	92.00
93.00	All other Medical Education	0	4,806,944	0.000000	381,071	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/25/2017 2:38 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		884,830		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.387110	1,135,615	439,608	50.00
53.00	05300	ANESTHESIOLOGY	0.109716	190,769	20,930	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.155938	376,670	58,737	54.00
60.00	06000	LABORATORY	0.207266	411,340	85,257	60.00
65.00	06500	RESPIRATORY THERAPY	1.535511	118,330	181,697	65.00
66.00	06600	PHYSICAL THERAPY	0.264100	308,860	81,570	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110421	16,314	1,801	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.408360	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.325406	694,339	225,942	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.596753	1,010,897	603,256	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.361020	625,976	225,990	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	0.901763	0	0	90.00
90.01	04951	CHEMO/PAIN	1.700732	96	163	90.01
90.02	09002	SENIOR CARE	1.121986	0	0	90.02
90.03	09003	SLEEP LAB	0.347270	0	0	90.03
91.00	09100	EMERGENCY	0.523424	8,046	4,211	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.368367	1,091	1,493	92.00
200.00		Total (sum of lines 50-94 and 96-98)		4,898,343	1,930,655	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)		4,898,343		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1320 | Component CCN: 14-Z320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/25/2017 2:38 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.387110	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.109716	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.155938	19,704	3,073	54.00
60.00	06000	LABORATORY	0.207266	41,945	8,694	60.00
65.00	06500	RESPIRATORY THERAPY	1.535511	33,473	51,398	65.00
66.00	06600	PHYSICAL THERAPY	0.264100	427,697	112,955	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110421	941	104	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.408360	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.325406	30,768	10,012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.596753	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.361020	109,042	39,366	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	0.901763	0	0	90.00
90.01	04951	CHEMO/PAIN	1.700732	0	0	90.01
90.02	09002	SENIOR CARE	1.121986	0	0	90.02
90.03	09003	SLEEP LAB	0.347270	0	0	90.03
91.00	09100	EMERGENCY	0.523424	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.368367	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		663,570	225,602	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)		663,570		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/25/2017 2:38 pm

Title XIX | 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		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.387110	1	0	50.00
53.00	05300	ANESTHESIOLOGY	0.109716	1	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.155938	1	0	54.00
60.00	06000	LABORATORY	0.207266	1	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.535511	1	2	65.00
66.00	06600	PHYSICAL THERAPY	0.264100	1	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110421	1	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.408360	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.325406	1	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.596753	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.361020	1	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.641487	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3.107466	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	88.02
90.00	09000	CLINIC	0.901763	0	0	90.00
90.01	04951	CHEMO/PAIN	1.700732	0	0	90.01
90.02	09002	SENIOR CARE	1.121986	0	0	90.02
90.03	09003	SLEEP LAB	0.347270	0	0	90.03
91.00	09100	EMERGENCY	0.523424	1	1	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.368367	1	1	92.00
200.00		Total (sum of lines 50-94 and 96-98)		11	4	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)		11		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part B Date/Time Prepared: 5/25/2017 2:38 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,060,275	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)	6,060,275	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)	6,120,878	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)	37,433	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,953,971	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)	3,129,474	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)	3,129,474	30.00
31.00	Primary payer payments	804	31.00
32.00	Subtotal (line 30 minus line 31)	3,128,670	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)	619,531	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	402,695	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	3,531,365	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)	3,531,365	40.00
40.01	Sequestration adjustment (see instructions)	70,627	40.01
41.00	Interim payments	3,091,615	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	369,123	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 5/25/2017 2:38 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,887,011		2,685,809	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		51,281		410,421	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	08/01/2016	384,049		0	3.01
3.02		12/01/2016	248,421		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	08/01/2016	4,615	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)		632,470		-4,615	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)		3,570,762		3,091,615	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		369,123	6.01
6.02	SETTLEMENT TO PROGRAM		20,524		0	6.02
7.00	Total Medicare program liability (see instructions)		3,550,238		3,460,738	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: 14-1320 | Component CCN: 14-Z320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2017 2:38 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		988,720		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	08/01/2016	101,327		0	3.01
3.02		12/01/2016	81,160		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)		182,487		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,171,207		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		78,213		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,249,420		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: 14-1320	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/25/2017 2:38 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	612	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,057	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,634	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	84,658,529	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	569,938	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	1	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1	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)	1	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1320 | Component CCN: 14-Z320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-2 | Date/Time Prepared: 5/25/2017 2:38 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,053,661	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)	227,858	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	553	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,281,519	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,281,519	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,281,519	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)	1,274,918	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,274,918	0	19.00
19.01	Sequestration adjustment (see instructions)	25,498	0	19.01
20.00	Interim payments	1,171,207	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)	78,213	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: 14-1320	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part V Date/Time Prepared: 5/25/2017 2:38 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,924,675	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)	3,924,675	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,963,922	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)	3,963,922	19.00
20.00	Deductibles (exclude professional component)	374,645	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,589,277	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,589,277	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	51,407	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	33,415	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,622,692	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)	3,622,692	30.00
30.01	Sequestration adjustment (see instructions)	72,454	30.01
31.00	Interim payments	3,570,762	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)	-20,524	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	275,385	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/25/2017 2:38 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	10,092,414	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	22,261,953	0	0	0	4.00
5.00	Other receivable	2,141,726	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-14,957,456	0	0	0	6.00
7.00	Inventory	1,367,712	0	0	0	7.00
8.00	Prepaid expenses	609,824	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)	21,516,173	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	43,361,587	0	0	0	15.00
16.00	Accumulated depreciation	-28,895,676	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	14,465,911	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	19,855,891	0	0	0	33.00
34.00	Other assets	147,268	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	20,003,159	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	55,985,243	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,901,551	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	1,874,723	0	0	0	39.00
40.00	Notes and loans payable (short term)	338,162	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	125,434	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,239,870	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	2,277,863	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,277,863	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	6,517,733	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	49,467,510				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)	49,467,510	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	55,985,243	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/25/2017 2:38 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		46,939,024		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,684,954				2.00
3.00	Total (sum of line 1 and line 2)		49,623,978		0		3.00
4.00	MISCELLANEOUS	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)		49,623,978		0		11.00
12.00	MISCELLANEOUS	156,468		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)		156,468		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		49,467,510		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	MISCELLANEOUS		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	MISCELLANEOUS		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: 14-1320 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/25/2017 2:38 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,659,562		1,659,562	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	730,660		730,660	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,390,222		2,390,222	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)	2,390,222		2,390,222	17.00
18.00	Ancillary services	10,536,266	45,559,088	56,095,354	18.00
19.00	Outpatient services	0	1,676,962	1,676,962	19.00
20.00	RURAL HEALTH CLINIC	0	10,525,266	10,525,266	20.00
20.01	RURAL HEALTH CLINIC II	0	161,261	161,261	20.01
20.02	RURAL HEALTH CLINIC III	0	0	0	20.02
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	PRO FEES	1,847,370	14,821,782	16,669,152	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	14,773,858	72,744,359	87,518,217	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		46,202,903		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	FMC EXPENSE	11,009,175			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)		11,009,175		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		35,193,728		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1320	Period: From 01/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Prepared: 5/25/2017 2:38 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	87,518,217	1.00
2.00	Less contractual allowances and discounts on patients' accounts	48,329,024	2.00
3.00	Net patient revenues (line 1 minus line 2)	39,189,193	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	35,193,728	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,995,465	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	1,472,936	24.00
24.01		0	24.01
25.00	Total other income (sum of lines 6-24)	1,472,936	25.00
26.00	Total (line 5 plus line 25)	5,468,401	26.00
27.00	NON-OPERATING INCOME	2,783,447	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2,783,447	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,684,954	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-3987 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-1 | Date/Time Prepared: 5/25/2017 2:38 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	2,189,399	0	2,189,399	0	2,189,399	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	65,628	0	65,628	0	65,628	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	518,563	0	518,563	0	518,563	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	58,304	0	58,304	0	58,304	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)	2,831,894	0	2,831,894	0	2,831,894	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	143,220	143,220	0	143,220	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	3,185	3,185	0	3,185	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	146,405	146,405	0	146,405	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,831,894	146,405	2,978,299	0	2,978,299	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	70,741	70,741	0	70,741	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	70,741	70,741	0	70,741	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	928,248	549,725	1,477,973	-126,550	1,351,423	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	928,248	549,725	1,477,973	-126,550	1,351,423	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,760,142	766,871	4,527,013	-126,550	4,400,463	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-3987 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-1 | Date/Time Prepared: 5/25/2017 2:38 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	2,189,399		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	65,628		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	518,563		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	58,304		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,831,894		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	143,220		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	3,185		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	146,405		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,978,299		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	70,741		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	70,741		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-171,757	1,179,666		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-171,757	1,179,666		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-171,757	4,228,706		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-3989 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-1 | Date/Time Prepared: 5/25/2017 2:38 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	91,668	0	91,668	0	91,668	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	3,095	0	3,095	0	3,095	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	11,248	0	11,248	0	11,248	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	4,782	0	4,782	0	4,782	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)	110,793	0	110,793	0	110,793	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	31,325	31,325	0	31,325	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	570	570	0	570	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	31,895	31,895	0	31,895	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	110,793	31,895	142,688	0	142,688	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	13,413	13,413	0	13,413	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	13,413	13,413	0	13,413	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	109,037	60,298	169,335	-622	168,713	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	109,037	60,298	169,335	-622	168,713	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	219,830	105,606	325,436	-622	324,814	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-3989 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-1 | Date/Time Prepared: 5/25/2017 2:38 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	91,668		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	3,095		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	11,248		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	4,782		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	110,793		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	31,325		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	570		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	31,895		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	142,688		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	13,413		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	13,413		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-2,075	166,638		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-2,075	166,638		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-2,075	322,739		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320 | Component CCN: 14-3987 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-2 | Date/Time Prepared: 5/25/2017 2:38 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	4.31	27,094	4,200	18,102		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	3.00	9,304	2,100	6,300		3.00
4.00	Subtotal (sum of lines 1 through 3)	7.31	36,398		24,402	36,398	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	7.31	36,398			36,398	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)					2,978,299	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					70,741	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,049,040	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.976799	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,179,666	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,523,113	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,702,779	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					3,702,779	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					3,616,871	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					6,595,170	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320 | Component CCN: 14-3989 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-2 | Date/Time Prepared: 5/25/2017 2:38 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC II Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.01	0	4,200	42		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.74	1,766	2,100	1,554		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.75	1,766		1,596	1,766	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.75	1,766			1,766	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)					142,688	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					13,413	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					156,101	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.914075	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					166,638	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					178,374	15.00
16.00	Total overhead (sum of lines 14 and 15)					345,012	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					345,012	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					315,367	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					458,055	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1320 Component CCN: 14-3987	Period: From 01/01/2016 To 12/31/2016	Worksheet M-3 Date/Time Prepared: 5/25/2017 2:38 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)		6,595,170	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		108,531	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		6,486,639	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		36,398	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)		36,398	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		178.21	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or 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)	999.00	999.00	8.00
9.00	Rate for Program covered visits (see instructions)	178.21	178.21	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	8,760	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,561,120	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,561,120	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,279,193	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		11,570	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		14,120	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.)		1,116,694	16.04
16.05	Total program cost (see instructions)	0	1,130,814	16.05
17.00	Primary payer amounts		1,220	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		151,132	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		223,298	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,129,594	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		108,531	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,238,125	22.00
23.00	Allowable bad debts (see instructions)		89,811	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		58,377	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)		1,296,502	26.00
26.01	Sequestration adjustment (see instructions)		25,930	26.01
27.00	Interim payments		959,251	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)		311,321	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1320 Component CCN: 14-3989	Period: From 01/01/2016 To 12/31/2016	Worksheet M-3 Date/Time Prepared: 5/25/2017 2:38 pm
	Title XVIII	RHC II	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)		458,055	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		12,997	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		445,058	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,766	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)		1,766	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		252.01	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or 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)	999.00	999.00	8.00
9.00	Rate for Program covered visits (see instructions)	252.01	252.01	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	357	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	89,968	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	89,968	16.00
16.01	Total program charges (see instructions)(from contractor's records)		53,303	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		922	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,556	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.)		64,384	16.04
16.05	Total program cost (see instructions)	0	65,940	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		7,932	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		8,890	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		65,940	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		12,997	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		78,937	22.00
23.00	Allowable bad debts (see instructions)		863	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		561	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)		79,498	26.00
26.01	Sequestration adjustment (see instructions)		1,590	26.01
27.00	Interim payments		40,002	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)		37,906	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: 14-1320 | Component CCN: 14-3987 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-4 | Date/Time Prepared: 5/25/2017 2:38 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)	2,831,894	2,831,894	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	41,348	7,664	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	41,348	7,664	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,978,299	2,978,299	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	3,616,871	3,616,871	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.013883	0.002573	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	50,213	9,306	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	91,561	16,970	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	277	460	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	330.55	36.89	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	277	460	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	91,562	16,969	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)		108,531	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)		108,531	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-1320 Component CCN: 14-3989	Period: From 01/01/2016 To 12/31/2016	Worksheet M-4 Date/Time Prepared: 5/25/2017 2:38 pm
	Title XVIII	RHC II	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	110,793	110,793	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	3,433	616	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	3,433	616	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	142,688	142,688	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	315,367	315,367	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.024059	0.004317	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	7,587	1,361	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	11,020	1,977	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	23	37	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	479.13	53.43	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	23	37	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	11,020	1,977	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)		12,997	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)		12,997	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1320 Component CCN: 14-3987	Period: From 01/01/2016 To 12/31/2016	Worksheet M-5 Date/Time Prepared: 5/25/2017 2:38 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		957,545	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		08/01/2016	87,377	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50		12/01/2016	85,671	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)		1,706	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		959,251	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		311,321	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,270,572	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1320 Component CCN: 14-3989	Period: From 01/01/2016 To 12/31/2016	Worksheet M-5 Date/Time Prepared: 5/25/2017 2:38 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		46,867	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50		08/01/2016	3,935	3.50
3.51		12/01/2016	2,930	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)		-6,865	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		40,002	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		37,906	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		77,908	7.00

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