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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141323	Period: From 04/01/2015 To 03/31/2016	Worksheet S Parts I-III Date/Time Prepared: 8/30/2016 8:33 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 8/30/2016 Time: 8:33 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MASSAC MEMORIAL HOSPITAL (141323) for the cost reporting period beginning 04/01/2015 and ending 03/31/2016 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	-78,330	1,873	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	-33,631	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		85,701		0	10.00
200.00	Total	0	-111,961	87,574	1	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 8/30/2016 8:31 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 28 CHICK STREET	PO Box:			1.00
2.00	City: METROPOLIS	State: IL	Zip Code: 62960-	County: MASSAC	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	MASSAC MEMORIAL HOSPITAL	141323	99916	1	02/03/2003	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MASSAC MEMORIAL HOSPITAL	14Z323	99916		02/03/2003	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	MASSAC MEMORIAL MEDICAL CLINIC	143478	99916		02/07/2006	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	04/01/2015	03/31/2016	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 8/30/2016 8:31 am

		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
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 8/30/2016 8:31 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 8/30/2016 8:31 am

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	370,221	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 8/30/2016 8:31 am

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

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

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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141323	Period: From 04/01/2015 To 03/31/2016	Worksheet S-2 Part I Date/Time Prepared: 8/30/2016 8:31 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2013	09/30/2014	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 8/30/2016 8:31 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	09/30/2013	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	08/17/2016	Y	08/17/2016	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: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 8/30/2016 8:31 am

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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.	KYLE	LEE	41.00
42.00	Enter the employer/company name of the cost report preparer.	MEDTRACK, INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	417-268-5953	KYLE.LEE@EDPTS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 141323	Period: From 04/01/2015 To 03/31/2016	Worksheet S-2 Part II Date/Time Prepared: 8/30/2016 8:31 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PRIN		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: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 8/30/2016 8:31 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	53,089.21	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	53,089.21	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,150	53,089.21	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		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: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 8/30/2016 8:31 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,411	283	2,913			1.00
2.00	HMO and other (see instructions)	94	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	570	0	570			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		107	107			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,981	390	3,590			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)	1,981	390	3,590	0.00	196.50	14.00
15.00	CAH visits	13,371	0	25,416			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	1,993	0	10,177	0.00	19.40	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	215.90	27.00
28.00	Observation Bed Days		0	159			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: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 8/30/2016 8:31 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	385	134	796	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	385	134	796	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

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

Provider CCN: 141323 Component CCN: 143478 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-8 | Date/Time Prepared: 8/30/2016 8:31 am

Rural Health Clinic (RHC) I | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			28 CHICK STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	METROPOLIS		IL	62960	2.00
					1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
				Grant Award	Date	
				1.00	2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			07:30	18:00	07:30	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	Provider name, CCN number			14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		MASSAC				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	18:00	07:30	18:00	07:30	18:00	11.00

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

Provider CCN: 141323
Component CCN: 143478

Period:
From 04/01/2015
To 03/31/2016

Worksheet S-8

Date/Time Prepared:
8/30/2016 8:31 am

Rural Health Clinic (RHC) I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	07:30	16:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-10 | Date/Time Prepared: 8/30/2016 8:31 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.422987	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,364,893	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	15,653,458	6.00
7.00	Medicaid cost (line 1 times line 6)	6,621,209	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,256,316	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,256,316	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	420,479	0	420,479	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	177,857	0	177,857	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	177,857	0	177,857	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?		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)	133,504	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	642,792	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	-509,288	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	-215,422	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	-37,565	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,218,751	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A | Date/Time Prepared: 8/30/2016 8:31 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,170,019	1,170,019	491,976	1,661,995	1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE		0	0	0	0	1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG		0	0	14,400	14,400	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,390,295	1,390,295	258,283	1,648,578	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	40,557	3,687,893	3,728,450	0	3,728,450	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,289,375	1,332,460	2,621,835	-42,285	2,579,550	5.00
7.00	00700	OPERATION OF PLANT	173,471	729,668	903,139	0	903,139	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,887	110,325	121,212	0	121,212	8.00
9.00	00900	HOUSEKEEPING	241,604	61,334	302,938	0	302,938	9.00
10.00	01000	DIETARY	266,674	192,057	458,731	-190,792	267,939	10.00
11.00	01100	CAFETERIA	0	0	0	190,649	190,649	11.00
13.00	01300	NURSING ADMINISTRATION	312,381	17,276	329,657	-682	328,975	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	206,676	93,180	299,856	-14,400	285,456	16.00
17.00	01700	SOCIAL SERVICE	18,178	4,973	23,151	0	23,151	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,117,374	230,268	1,347,642	19,979	1,367,621	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	289,522	287,115	576,637	-144,192	432,445	50.00
53.00	05300	ANESTHESIOLOGY	0	267,690	267,690	0	267,690	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	532,136	581,748	1,113,884	-133,425	980,459	54.00
60.00	06000	LABORATORY	424,870	730,139	1,155,009	-4,141	1,150,868	60.00
65.00	06500	RESPIRATORY THERAPY	322,439	104,600	427,039	-29,864	397,175	65.00
66.00	06600	PHYSICAL THERAPY	390,048	6,557	396,605	-78	396,527	66.00
69.00	06900	ELECTROCARDIOLOGY	59,691	212,935	272,626	24,652	297,278	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	46,218	3,407	49,625	35,950	85,575	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	30,374	30,374	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	230,053	469,190	699,243	17,421	716,664	73.00
76.00	03020	GERIATRIC PSYCH	190,087	123,588	313,675	0	313,675	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	956,750	317,587	1,274,337	-42,808	1,231,529	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	49,743	49,743	0	49,743	90.01
91.00	09100	EMERGENCY	699,799	710,782	1,410,581	-13,923	1,396,658	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	15,803	15,803	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	227,747	77,134	304,881	-880	304,001	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		489,596	489,596	-489,596	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,046,537	13,451,559	21,498,096	-7,579	21,490,517	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	7,579	7,579	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	8,046,537	13,451,559	21,498,096	0	21,498,096	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A | Date/Time Prepared: 8/30/2016 8:31 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-79,995	1,582,000		1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	0		1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	14,400		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,066,652	581,926		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-243	3,728,207		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-55,949	2,523,601		5.00
7.00	00700	OPERATION OF PLANT	0	903,139		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	121,212		8.00
9.00	00900	HOUSEKEEPING	0	302,938		9.00
10.00	01000	DIETARY	-248	267,691		10.00
11.00	01100	CAFETERIA	0	190,649		11.00
13.00	01300	NURSING ADMINISTRATION	0	328,975		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,075	284,381		16.00
17.00	01700	SOCIAL SERVICE	0	23,151		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-159,006	1,208,615		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	432,445		50.00
53.00	05300	ANESTHESIOLOGY	-266,015	1,675		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	980,459		54.00
60.00	06000	LABORATORY	0	1,150,868		60.00
65.00	06500	RESPIRATORY THERAPY	0	397,175		65.00
66.00	06600	PHYSICAL THERAPY	0	396,527		66.00
69.00	06900	ELECTROCARDIOLOGY	-135,237	162,041		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-1,170	84,405		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	30,374		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-5,298	711,366		73.00
76.00	03020	GERIATRIC PSYCH	-667	313,008		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-170	1,231,359		88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.00
90.01	04951	WOUND CARE	0	49,743		90.01
91.00	09100	EMERGENCY	0	1,396,658		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	15,803		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	304,001		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,771,725	19,718,792		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,579		192.00
192.01	19201	PROMOTION	0	0		192.01
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118-199)	-1,771,725	19,726,371		200.00

RECLASSIFICATIONS | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A-6 | Date/Time Prepared: 8/30/2016 8:31 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	463,287		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	26,309		2.00
	TOTALS		0	489,596		
	B - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	110,830	79,819		1.00
	TOTALS		110,830	79,819		
	C - RENTAL EXPENSE RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	231,974		1.00
2.00	NEW CAP REL COSTS-BLDG EKG	1.02	0	14,400		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	TOTALS		0	246,374		
	D - MED SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	35,950		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
	TOTALS		0	35,950		
	E - DRUGS CHARGED RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	17,421		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
	TOTALS		0	17,421		
	F - POB REAL ESTATE TAXES					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	7,579		1.00
	TOTALS		0	7,579		
	G - IMPLANTABLE SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	30,374		1.00
	TOTALS		0	30,374		
	I - RECLASS EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	24,652	0		1.00
	TOTALS		24,652	0		
	J - RECLASS RHC BLDG DEPRECIATION					
1.00	RURAL HEALTH CLINIC	88.00	0	6,017		1.00
	TOTALS		0	6,017		
	K - PROPERTY INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	34,706		1.00
	TOTALS		0	34,706		
	L - HOSPITALIST					
1.00	ADULTS & PEDIATRICS	30.00	38,480	0		1.00
	TOTALS		38,480	0		
	M - BLOOD TRANSFUSION					
1.00	OTHER OUTPATIENT SERVICES	93.00	15,803	0		1.00
2.00		0.00	0	0		2.00
	TOTALS		15,803	0		
500.00	Grand Total: Increases		189,765	947,836		500.00

RECLASSIFICATIONS | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A-6 | Date/Time Prepared: 8/30/2016 8:31 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - INTEREST RECLASS					
1.00	INTEREST EXPENSE	113.00	0	489,596	11	1.00
2.00		0.00	0	0	11	2.00
	TOTALS		0	489,596		
	B - CAFETERIA RECLASS					
1.00	DIETARY	10.00	110,830	79,819	0	1.00
	TOTALS		110,830	79,819		
	C - RENTAL EXPENSE RECLASS					
1.00	OPERATING ROOM	50.00	0	94,559	10	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	128,301	10	2.00
3.00	LABORATORY	60.00	0	4,140	0	3.00
4.00	RESPIRATORY THERAPY	65.00	0	4,974	0	4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	14,400	0	5.00
	TOTALS		0	246,374		
	D - MED SUPPLIES RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	3,639	0	1.00
2.00	OPERATING ROOM	50.00	0	18,771	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	160	0	3.00
4.00	LABORATORY	60.00	0	1	0	4.00
5.00	RESPIRATORY THERAPY	65.00	0	238	0	5.00
6.00	RURAL HEALTH CLINIC	88.00	0	139	0	6.00
7.00	EMERGENCY	91.00	0	12,852	0	7.00
8.00	AMBULANCE SERVICES	95.00	0	150	0	8.00
	TOTALS		0	35,950		
	E - DRUGS CHARGED RECLASS					
1.00	DIETARY	10.00	0	143	0	1.00
2.00	NURSING ADMINISTRATION	13.00	0	682	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	85	0	3.00
4.00	OPERATING ROOM	50.00	0	488	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,964	0	5.00
6.00	PHYSICAL THERAPY	66.00	0	78	0	6.00
7.00	RURAL HEALTH CLINIC	88.00	0	10,206	0	7.00
8.00	EMERGENCY	91.00	0	45	0	8.00
9.00	AMBULANCE SERVICES	95.00	0	730	0	9.00
	TOTALS		0	17,421		
	F - POB REAL ESTATE TAXES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,579	0	1.00
	TOTALS		0	7,579		
	G - IMPLANTABLE SUPPLIES					
1.00	OPERATING ROOM	50.00	0	30,374	0	1.00
	TOTALS		0	30,374		
	I - RECLASS EKG SALARIES					
1.00	RESPIRATORY THERAPY	65.00	24,652	0	0	1.00
	TOTALS		24,652	0		
	J - RECLASS RHC BLDG DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,017	9	1.00
	TOTALS		0	6,017		
	K - PROPERTY INSURANCE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	34,706	12	1.00
	TOTALS		0	34,706		
	L - HOSPITALIST					
1.00	RURAL HEALTH CLINIC	88.00	38,480	0	0	1.00
	TOTALS		38,480	0		
	M - BLOOD TRANSFUSION					
1.00	ADULTS & PEDIATRICS	30.00	14,777	0	0	1.00
2.00	EMERGENCY	91.00	1,026	0	0	2.00
	TOTALS		15,803	0		
500.00	Grand Total: Decreases		189,765	947,836		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 8/30/2016 8:31 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	65,980	0	0	0	0	1.00
2.00	Land Improvements	1,054,078	21,342	0	21,342	0	2.00
3.00	Buildings and Fixtures	16,883,008	95,324	0	95,324	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	6,781,884	689,868	0	689,868	0	6.00
7.00	HIT designated Assets	268,242	275,336	0	275,336	118,794	7.00
8.00	Subtotal (sum of lines 1-7)	25,053,192	1,081,870	0	1,081,870	118,794	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	25,053,192	1,081,870	0	1,081,870	118,794	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	65,980	0	1.00
2.00	Land Improvements	1,075,420	0	2.00
3.00	Buildings and Fixtures	16,978,332	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	7,471,752	0	6.00
7.00	HIT designated Assets	424,784	0	7.00
8.00	Subtotal (sum of lines 1-7)	26,016,268	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	26,016,268	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A-7 Part II Date/Time Prepared: 8/30/2016 8:31 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,170,019	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	1,390,295	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,560,314	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,170,019	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,390,295	2.00
3.00	Total (sum of lines 1-2)	0	2,560,314	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 8/30/2016 8:31 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	18,053,752	-61,127	18,114,879	0.708179	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0.000000	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	7,471,752	7,128	7,464,624	0.291821	0	2.00
3.00	Total (sum of lines 1-2)	25,525,504	-53,999	25,579,503	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,164,002	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	14,400	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	328,186	231,974	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,492,188	246,374	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	383,292	34,706	0	0	1,582,000	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	14,400	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	21,766	0	0	0	581,926	2.00
3.00	Total (sum of lines 1-2)	405,058	34,706	0	0	2,178,326	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A-8 | Date/Time Prepared: 8/30/2016 8:31 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-79,995	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - NEW CAP REL COSTS-BLDG AMBULANCE (chapter 2)		0	NEW CAP REL COSTS-BLDG AMBULANCE	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-BLDG EKG (chapter 2)		0	NEW CAP REL COSTS-BLDG EKG	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-4,543	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-7,351	ADMINISTRATIVE & GENERAL	5.00	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	-294,243			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		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	A	-1,075	MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-BLDG AMBULANCE		0	NEW CAP REL COSTS-BLDG AMBULANCE	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-BLDG EKG		0	NEW CAP REL COSTS-BLDG EKG	1.02	0	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A-8 | Date/Time Prepared: 8/30/2016 8:31 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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
33.00	PHYSICIAN RECRUITMENT	A	-17,519	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	OTHER OPERATING REVENUE	B	-248	DIETARY	10.00	0	34.00
35.00	PHARMACY REBATES	B	-5,298	DRUGS CHARGED TO PATIENTS	73.00	0	35.00
36.00	OTHER REVENUE	B	-12,964	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	ACCOUNTS PAYABLE DISCOUNT	B	-156	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	PURCHASING REBATES	B	-1,170	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	38.00
39.00	BILLING REC	B	-270	ADMINISTRATIVE & GENERAL	5.00	0	39.00
42.00	LOBBYING EXPENSE	A	-2,401	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	CRNA EXPENSES	A	-266,015	ANESTHESIOLOGY	53.00	0	43.00
44.00	RHC MISC INCOME	B	-170	RURAL HEALTH CLINIC	88.00	0	44.00
45.00	COMMUNITY OUTREACH	A	-667	GERIATRIC PSYCH	76.00	0	45.00
45.01	PATIENT TV DEPRECIATION	A	-1,861	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.01
45.02	PATIENT PHONE SALARY	A	-896	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	PATIENT PHONE BENEFITS	A	-243	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.03
45.04	PATIENT PHONE DEPRECIATION	A	-1,934	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.04
45.05	MARKETING EXPENSE	A	-14,392	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	HITECH DEPRECIATION	A	-1,058,314	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,771,725				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: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 8/30/2016 8:31 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	159,006	159,006	0	0	0	1.00
2.00	91.00	EMERGENCY	642,173	0	642,173	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	135,237	135,237	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	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			936,416	294,243	642,173		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	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	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	159,006		1.00
2.00	91.00	EMERGENCY	0	0	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	135,237		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	294,243		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B Part I Date/Time Prepared: 8/30/2016 8:31 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW BLDG AMBULANCE	NEW BLDG EKG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,582,000	1,582,000				1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0			1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	14,400	0	0	14,400		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	581,926				581,926	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,728,207	7,318	0	0	2,520	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,523,601	393,321	0	0	135,456	5.00
7.00	00700	OPERATION OF PLANT	903,139	140,593	0	0	48,419	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	121,212	29,272	0	0	10,081	8.00
9.00	00900	HOUSEKEEPING	302,938	10,779	0	0	3,712	9.00
10.00	01000	DIETARY	267,691	35,238	0	0	12,136	10.00
11.00	01100	CAFETERIA	190,649	14,744	0	0	5,078	11.00
13.00	01300	NURSING ADMINISTRATION	328,975	6,128	0	0	2,111	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	284,381	27,740	0	14,400	10,745	16.00
17.00	01700	SOCIAL SERVICE	23,151	3,262	0	0	1,124	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,208,615	265,181	0	0	91,326	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	432,445	162,746	0	0	56,048	50.00
53.00	05300	ANESTHESIOLOGY	1,675	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	980,459	88,267	0	0	30,399	54.00
60.00	06000	LABORATORY	1,150,868	21,468	0	0	7,393	60.00
65.00	06500	RESPIRATORY THERAPY	397,175	29,687	0	0	10,224	65.00
66.00	06600	PHYSICAL THERAPY	396,527	62,492	0	0	21,522	66.00
69.00	06900	ELECTROCARDIOLOGY	162,041	55,012	0	0	19,132	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	84,405	24,910	0	0	8,579	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,374	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	711,366	10,274	0	0	3,538	73.00
76.00	03020	GERIATRIC PSYCH	313,008	26,010	0	0	8,958	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,231,359	33,562	0	0	36,389	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	49,743	25,235	0	0	0	90.01
91.00	09100	EMERGENCY	1,396,658	105,733	0	0	36,414	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	15,803	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	304,001	0	0	0	19,579	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,718,792	1,578,972	0	14,400	580,883	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,028	0	0	1,043	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,579	0	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	19,726,371	1,582,000	0	14,400	581,926	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B Part I | Date/Time Prepared: 8/30/2016 8:31 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,738,045					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	602,014	3,654,392	3,654,392			5.00
7.00	00700	OPERATION OF PLANT	80,995	1,173,146	266,746	1,439,892		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,083	165,648	37,665	40,498	243,811	8.00
9.00	00900	HOUSEKEEPING	112,807	430,236	97,826	14,912	0	9.00
10.00	01000	DIETARY	72,765	387,830	88,184	48,752	3,019	10.00
11.00	01100	CAFETERIA	51,747	262,218	59,622	20,399	0	11.00
13.00	01300	NURSING ADMINISTRATION	145,853	483,067	109,838	8,479	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	96,498	433,764	98,628	38,378	0	16.00
17.00	01700	SOCIAL SERVICE	8,487	36,024	8,191	4,514	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	532,777	2,097,899	477,009	366,874	106,341	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	135,180	786,419	178,814	225,157	25,251	50.00
53.00	05300	ANESTHESIOLOGY	0	1,675	381	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	248,458	1,347,583	306,409	122,117	28,776	54.00
60.00	06000	LABORATORY	198,375	1,378,104	313,349	29,700	0	60.00
65.00	06500	RESPIRATORY THERAPY	139,039	576,125	130,998	41,071	0	65.00
66.00	06600	PHYSICAL THERAPY	182,116	662,657	150,673	86,457	1,762	66.00
69.00	06900	ELECTROCARDIOLOGY	39,380	275,565	62,657	76,108	5,706	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,580	139,474	31,713	34,463	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	30,374	6,906	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,413	832,591	189,312	14,214	0	73.00
76.00	03020	GERIATRIC PSYCH	88,753	436,729	99,302	35,984	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	428,747	1,730,057	393,375	46,433	1,331	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	74,978	17,048	34,912	0	90.01
91.00	09100	EMERGENCY	326,262	1,865,067	424,073	146,281	65,611	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
93.00	04040	OTHER OUTPATIENT SERVICES	7,379	23,182	5,271	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	106,337	429,917	97,753	0	3,512	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,738,045	19,714,721	3,651,743	1,435,703	241,309	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,071	926	4,189	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,579	1,723	0	2,502	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,738,045	19,726,371	3,654,392	1,439,892	243,811	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B Part I Date/Time Prepared: 8/30/2016 8:31 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	542,974					9.00
10.00	01000	DIETARY	28,657	556,442				10.00
11.00	01100	CAFETERIA	0	187,034	529,273			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	35,937	637,321		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,467	0	29,345	0	607,582	16.00
17.00	01700	SOCIAL SERVICE	0	0	2,073	23,310	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	206,359	292,618	133,434	364,034	319,072	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,963	0	24,348	56,977	34,030	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,892	0	54,437	0	107,183	54.00
60.00	06000	LABORATORY	21,435	0	52,523	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	23,812	0	35,299	0	0	65.00
66.00	06600	PHYSICAL THERAPY	14,689	0	39,605	0	23,418	66.00
69.00	06900	ELECTROCARDIOLOGY	1,641	0	7,496	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	10,420	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,680	0	18,872	0	0	73.00
76.00	03020	GERIATRIC PSYCH	0	32,566	17,490	43,015	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	52,039	0	0	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	102,315	0	67,462	149,985	123,879	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	504,949	512,218	528,741	637,321	607,582	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,025	44,224	532	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	542,974	556,442	529,273	637,321	607,582	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B Part I | Date/Time Prepared: 8/30/2016 8:31 am

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	74,112					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	74,112	0	4,437,752	0	4,437,752	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	1,332,959	0	1,332,959	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,056	0	2,056	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,007,397	0	2,007,397	54.00
60.00	06000	LABORATORY	0	0	1,795,111	0	1,795,111	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	807,305	0	807,305	65.00
66.00	06600	PHYSICAL THERAPY	0	0	979,261	0	979,261	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	429,173	0	429,173	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	216,070	0	216,070	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	37,280	0	37,280	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,058,669	0	1,058,669	73.00
76.00	03020	GERIATRIC PSYCH	0	0	665,086	0	665,086	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	2,223,235	0	2,223,235	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	126,938	0	126,938	90.01
91.00	09100	EMERGENCY	0	0	2,944,673	0	2,944,673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	28,453	0	28,453	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	531,182	0	531,182	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	74,112	0	19,622,600	0	19,622,600	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	9,186	0	9,186	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	94,585	0	94,585	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	74,112	0	19,726,371	0	19,726,371	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B Part II Date/Time Prepared: 8/30/2016 8:31 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	NEW BLDG AMBULANCE	NEW BLDG EKG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,318	0	0	2,520	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	393,321	0	0	135,456	5.00
7.00	00700	OPERATION OF PLANT	0	140,593	0	0	48,419	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	29,272	0	0	10,081	8.00
9.00	00900	HOUSEKEEPING	0	10,779	0	0	3,712	9.00
10.00	01000	DIETARY	0	35,238	0	0	12,136	10.00
11.00	01100	CAFETERIA	0	14,744	0	0	5,078	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,128	0	0	2,111	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,740	0	14,400	10,745	16.00
17.00	01700	SOCIAL SERVICE	0	3,262	0	0	1,124	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	265,181	0	0	91,326	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	162,746	0	0	56,048	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	88,267	0	0	30,399	54.00
60.00	06000	LABORATORY	0	21,468	0	0	7,393	60.00
65.00	06500	RESPIRATORY THERAPY	0	29,687	0	0	10,224	65.00
66.00	06600	PHYSICAL THERAPY	0	62,492	0	0	21,522	66.00
69.00	06900	ELECTROCARDIOLOGY	0	55,012	0	0	19,132	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	24,910	0	0	8,579	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,274	0	0	3,538	73.00
76.00	03020	GERIATRIC PSYCH	0	26,010	0	0	8,958	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	33,562	0	0	36,389	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	25,235	0	0	0	90.01
91.00	09100	EMERGENCY	0	105,733	0	0	36,414	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	19,579	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,578,972	0	14,400	580,883	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,028	0	0	1,043	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,582,000	0	14,400	581,926	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B Part II | Date/Time Prepared: 8/30/2016 8:31 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,838	9,838				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	528,777	1,583	530,360			5.00
7.00	00700	OPERATION OF PLANT	189,012	213	38,713	227,938		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	39,353	13	5,466	6,411	51,243	8.00
9.00	00900	HOUSEKEEPING	14,491	297	14,197	2,361	0	9.00
10.00	01000	DIETARY	47,374	192	12,798	7,718	635	10.00
11.00	01100	CAFETERIA	19,822	136	8,653	3,229	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,239	384	15,941	1,342	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	52,885	254	14,314	6,075	0	16.00
17.00	01700	SOCIAL SERVICE	4,386	22	1,189	715	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	356,507	1,402	69,229	58,076	22,350	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	218,794	356	25,951	35,643	5,307	50.00
53.00	05300	ANESTHESIOLOGY	0	0	55	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	118,666	654	44,469	19,331	6,048	54.00
60.00	06000	LABORATORY	28,861	522	45,476	4,702	0	60.00
65.00	06500	RESPIRATORY THERAPY	39,911	366	19,012	6,502	0	65.00
66.00	06600	PHYSICAL THERAPY	84,014	479	21,867	13,686	370	66.00
69.00	06900	ELECTROCARDIOLOGY	74,144	104	9,093	12,048	1,199	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	33,489	57	4,603	5,456	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,002	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,812	283	27,475	2,250	0	73.00
76.00	03020	GERIATRIC PSYCH	34,968	234	14,412	5,696	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	69,951	1,129	57,090	7,350	280	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	25,235	0	2,474	5,527	0	90.01
91.00	09100	EMERGENCY	142,147	859	61,545	23,157	13,790	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	19	765	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	19,579	280	14,187	0	738	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,174,255	9,838	529,976	227,275	50,717	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,071	0	134	663	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	250	0	526	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,178,326	9,838	530,360	227,938	51,243	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B Part II | Date/Time Prepared: 8/30/2016 8:31 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	31,346					9.00
10.00	01000	DIETARY	1,654	70,371				10.00
11.00	01100	CAFETERIA	0	23,653	55,493			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	3,768	29,674		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	431	0	3,077	0	77,036	16.00
17.00	01700	SOCIAL SERVICE	0	0	217	1,085	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,914	37,006	13,990	16,950	40,455	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	113	0	2,553	2,653	4,315	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,361	0	5,708	0	13,590	54.00
60.00	06000	LABORATORY	1,237	0	5,507	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,375	0	3,701	0	0	65.00
66.00	06600	PHYSICAL THERAPY	848	0	4,152	0	2,969	66.00
69.00	06900	ELECTROCARDIOLOGY	95	0	786	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,092	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	212	0	1,979	0	0	73.00
76.00	03020	GERIATRIC PSYCH	0	4,119	1,834	2,003	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,004	0	0	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	5,907	0	7,073	6,983	15,707	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,151	64,778	55,437	29,674	77,036	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,195	5,593	56	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	31,346	70,371	55,493	29,674	77,036	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B Part II Date/Time Prepared: 8/30/2016 8:31 am

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	7,614					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,614		635,493	0	635,493	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		295,685	0	295,685	50.00
53.00	05300	ANESTHESIOLOGY	0		55	0	55	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		210,827	0	210,827	54.00
60.00	06000	LABORATORY	0		86,305	0	86,305	60.00
65.00	06500	RESPIRATORY THERAPY	0		70,867	0	70,867	65.00
66.00	06600	PHYSICAL THERAPY	0		128,385	0	128,385	66.00
69.00	06900	ELECTROCARDIOLOGY	0		97,469	0	97,469	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		44,697	0	44,697	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		1,002	0	1,002	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		46,011	0	46,011	73.00
76.00	03020	GERIATRIC PSYCH	0		63,266	0	63,266	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		138,804	0	138,804	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	90.00
90.01	04951	WOUND CARE	0		33,236	0	33,236	90.01
91.00	09100	EMERGENCY	0		277,168	0	277,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0		784	0	784	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		34,784	0	34,784	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,614	0	2,164,838	0	2,164,838	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		4,868	0	4,868	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		8,620	0	8,620	192.00
192.01	19201	PROMOTION	0		0	0	0	192.01
193.00	19300	NONPAID WORKERS	0		0	0	0	193.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,614	0	2,178,326	0	2,178,326	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B-1 | Date/Time Prepared: 8/30/2016 8:31 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW BLDG AMBULANCE (SQUARE FEET)	NEW BLDG EKG (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	1.02	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	87,768					1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	0				1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0	1,642			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				93,744		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	406	0	0	406	8,005,980	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,821	0	0	21,821	1,289,375	5.00
7.00	00700	OPERATION OF PLANT	7,800	0	0	7,800	173,471	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,624	0	0	1,624	10,887	8.00
9.00	00900	HOUSEKEEPING	598	0	0	598	241,604	9.00
10.00	01000	DIETARY	1,955	0	0	1,955	155,844	10.00
11.00	01100	CAFETERIA	818	0	0	818	110,830	11.00
13.00	01300	NURSING ADMINISTRATION	340	0	0	340	312,381	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,539	0	1,642	1,731	206,676	16.00
17.00	01700	SOCIAL SERVICE	181	0	0	181	18,178	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,712	0	0	14,712	1,141,077	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,029	0	0	9,029	289,522	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,897	0	0	4,897	532,136	54.00
60.00	06000	LABORATORY	1,191	0	0	1,191	424,870	60.00
65.00	06500	RESPIRATORY THERAPY	1,647	0	0	1,647	297,787	65.00
66.00	06600	PHYSICAL THERAPY	3,467	0	0	3,467	390,048	66.00
69.00	06900	ELECTROCARDIOLOGY	3,052	0	0	3,082	84,343	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,382	0	0	1,382	46,218	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	570	0	0	570	230,053	73.00
76.00	03020	GERIATRIC PSYCH	1,443	0	0	1,443	190,087	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,862	0	0	5,862	918,270	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	1,400	0	0	0	0	90.01
91.00	09100	EMERGENCY	5,866	0	0	5,866	698,773	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	15,803	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	3,154	227,747	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	87,600	0	1,642	93,576	8,005,980	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	168	0	0	168	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,582,000	0	14,400	581,926	3,738,045	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.024793	0.000000	8.769793	6.207608	0.466907	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					9,838	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.001229	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B-1 | Date/Time Prepared: 8/30/2016 8:31 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	
			5A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,654,392	16,071,979				5.00
7.00	00700	OPERATION OF PLANT	0	1,173,146	57,741			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	165,648	1,624	19,784		8.00
9.00	00900	HOUSEKEEPING	0	430,236	598	0	177,065	9.00
10.00	01000	DIETARY	0	387,830	1,955	245	9,345	10.00
11.00	01100	CAFETERIA	0	262,218	818	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	483,067	340	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	433,764	1,539	0	2,435	16.00
17.00	01700	SOCIAL SERVICE	0	36,024	181	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,097,899	14,712	8,629	67,295	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	786,419	9,029	2,049	640	50.00
53.00	05300	ANESTHESIOLOGY	0	1,675	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,347,583	4,897	2,335	13,335	54.00
60.00	06000	LABORATORY	0	1,378,104	1,191	0	6,990	60.00
65.00	06500	RESPIRATORY THERAPY	0	576,125	1,647	0	7,765	65.00
66.00	06600	PHYSICAL THERAPY	0	662,657	3,467	143	4,790	66.00
69.00	06900	ELECTROCARDIOLOGY	0	275,565	3,052	463	535	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	139,474	1,382	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	30,374	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	832,591	570	0	1,200	73.00
76.00	03020	GERIATRIC PSYCH	0	436,729	1,443	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,730,057	1,862	108	16,970	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	74,978	1,400	0	0	90.01
91.00	09100	EMERGENCY	0	1,865,067	5,866	5,324	33,365	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	23,182	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	429,917	0	285	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,654,392	16,060,329	57,573	19,581	164,665	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,071	168	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,579	0	203	12,400	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		3,654,392	1,439,892	243,811	542,974	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.227377	24.937081	12.323645	3.066524	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		530,360	227,938	51,243	31,346	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.032999	3.947594	2.590123	0.177031	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B-1 | Date/Time Prepared: 8/30/2016 8:31 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	NURSING ADMINISTRATION (NURSING FTES)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (ASSIGNEDTIMES)	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	32,601					10.00
11.00	01100	CAFETERIA	10,958	9,956				11.00
13.00	01300	NURSING ADMINISTRATION	0	676	117,729			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	552	0	214,700		16.00
17.00	01700	SOCIAL SERVICE	0	39	4,306	0	100	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,144	2,510	67,246	112,750	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	458	10,525	12,025	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,024	0	37,875	0	54.00
60.00	06000	LABORATORY	0	988	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	664	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	745	0	8,275	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	141	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	196	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	355	0	0	0	73.00
76.00	03020	GERIATRIC PSYCH	1,908	329	7,946	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	1,269	27,706	43,775	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,010	9,946	117,729	214,700	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,591	10	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	556,442	529,273	637,321	607,582	74,112	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.068249	53.161209	5.413458	2.829912	741.120000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	70,371	55,493	29,674	77,036	7,614	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.158553	5.573825	0.252053	0.358808	76.140000	205.00

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		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			19.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE			1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03020	GERIATRIC PSYCH	0		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0		88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0		90.00
90.01	04951	WOUND CARE	0		90.01
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
192.01	19201	PROMOTION	0		192.01
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B-2 | Date/Time Prepared: 8/30/2016 8:31 am

		Description	Worksheet Part	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet C Part I Date/Time Prepared: 8/30/2016 8:31 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,437,752		4,437,752	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,332,959		1,332,959	0	0	50.00
53.00	05300	ANESTHESIOLOGY	2,056		2,056	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,007,397		2,007,397	0	0	54.00
60.00	06000	LABORATORY	1,795,111		1,795,111	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	807,305	0	807,305	0	0	65.00
66.00	06600	PHYSICAL THERAPY	979,261	0	979,261	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	429,173		429,173	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	216,070		216,070	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,280		37,280	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,058,669		1,058,669	0	0	73.00
76.00	03020	GERIATRIC PSYCH	665,086		665,086	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,223,235		2,223,235	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	90.00
90.01	04951	WOUND CARE	126,938		126,938	0	0	90.01
91.00	09100	EMERGENCY	2,944,673		2,944,673	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	193,121		193,121		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	28,453		28,453	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	531,182		531,182	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	19,815,721	0	19,815,721	0	0	200.00
201.00		Less Observation Beds	193,121		193,121		0	201.00
202.00		Total (see instructions)	19,622,600	0	19,622,600	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet C Part I Date/Time Prepared: 8/30/2016 8:31 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,285,816		2,285,816			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,582	2,728,307	2,740,889	0.486324	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	3,136	590,621	593,757	0.003463	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,313,434	16,798,596	19,112,030	0.105033	0.000000	54.00
60.00	06000	LABORATORY	1,390,764	4,056,641	5,447,405	0.329535	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,202,245	283,899	1,486,144	0.543221	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	101,615	1,066,317	1,167,932	0.838457	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	663,646	2,001,205	2,664,851	0.161050	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,655	24,769	33,424	6.464517	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	57,941	57,941	0.643413	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,115,610	1,052,930	2,168,540	0.488194	0.000000	73.00
76.00	03020	GERIATRIC PSYCH	1,265	637,756	639,021	1.040789	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	847,332	847,332			88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	90.00
90.01	04951	WOUND CARE	0	166,103	166,103	0.764213	0.000000	90.01
91.00	09100	EMERGENCY	541,847	4,540,683	5,082,530	0.579371	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9,405	93,223	102,628	1.881757	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	82,880	82,880	0.343304	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,205	1,710,106	1,711,311	0.310395	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	9,651,225	36,739,309	46,390,534			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,651,225	36,739,309	46,390,534			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet C Part I Date/Time Prepared: 8/30/2016 8:31 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	GERIATRIC PSYCH	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		90.00
90.01	04951	WOUND CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part II Date/Time Prepared: 8/30/2016 8:31 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	295,685	2,740,889	0.107879	0	0	50.00
53.00	05300	ANESTHESIOLOGY	55	593,757	0.000093	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	210,827	19,112,030	0.011031	609,759	6,726	54.00
60.00	06000	LABORATORY	86,305	5,447,405	0.015843	654,938	10,376	60.00
65.00	06500	RESPIRATORY THERAPY	70,867	1,486,144	0.047685	575,872	27,460	65.00
66.00	06600	PHYSICAL THERAPY	128,385	1,167,932	0.109925	7,380	811	66.00
69.00	06900	ELECTROCARDIOLOGY	97,469	2,664,851	0.036576	293,654	10,741	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	44,697	33,424	1.337273	5,640	7,542	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,002	57,941	0.017293	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	46,011	2,168,540	0.021218	554,429	11,764	73.00
76.00	03020	GERIATRIC PSYCH	63,266	639,021	0.099005	759	75	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	138,804	847,332	0.163813	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	90.00
90.01	04951	WOUND CARE	33,236	166,103	0.200093	0	0	90.01
91.00	09100	EMERGENCY	277,168	5,082,530	0.054533	2,345	128	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	27,655	102,628	0.269468	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	784	82,880	0.009459	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,522,216	42,393,407		2,704,776	75,623	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part IV Date/Time Prepared: 8/30/2016 8:31 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	GERIATRIC PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part IV Date/Time Prepared: 8/30/2016 8:31 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,740,889	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	593,757	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,112,030	0.000000	0.000000	609,759	54.00
60.00	06000	LABORATORY	0	5,447,405	0.000000	0.000000	654,938	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,486,144	0.000000	0.000000	575,872	65.00
66.00	06600	PHYSICAL THERAPY	0	1,167,932	0.000000	0.000000	7,380	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,664,851	0.000000	0.000000	293,654	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	33,424	0.000000	0.000000	5,640	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	57,941	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,168,540	0.000000	0.000000	554,429	73.00
76.00	03020	GERIATRIC PSYCH	0	639,021	0.000000	0.000000	759	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	847,332	0.000000	0.000000	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	90.00
90.01	04951	WOUND CARE	0	166,103	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	5,082,530	0.000000	0.000000	2,345	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	102,628	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	82,880	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	42,393,407			2,704,776	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part IV | Date/Time Prepared: 8/30/2016 8:31 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	GERIATRIC PSYCH	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		90.00
90.01	04951	WOUND CARE	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part V Date/Time Prepared: 8/30/2016 8:31 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.486324	0	1,057,832	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.003463	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.105033	0	5,719,850	0	0	54.00
60.00	06000	LABORATORY	0.329535	0	1,528,964	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.543221	0	75,916	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.838457	0	249,765	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.161050	0	777,346	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6.464517	0	24,021	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.643413	0	44,125	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488194	0	620,212	0	0	73.00
76.00	03020	GERIATRIC PSYCH	1.040789	0	637,756	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.00
90.01	04951	WOUND CARE	0.764213	0	66,794	0	0	90.01
91.00	09100	EMERGENCY	0.579371	0	1,246,727	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.881757	0	33,523	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.343304	0	58,519	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.310395		0			95.00
200.00		Subtotal (see instructions)		0	12,141,350	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	12,141,350	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part V Date/Time Prepared: 8/30/2016 8:31 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	514,449	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	600,773	0	54.00
60.00	06000	LABORATORY	503,847	0	60.00
65.00	06500	RESPIRATORY THERAPY	41,239	0	65.00
66.00	06600	PHYSICAL THERAPY	209,417	0	66.00
69.00	06900	ELECTROCARDIOLOGY	125,192	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	155,284	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,391	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	302,784	0	73.00
76.00	03020	GERIATRIC PSYCH	663,769	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	90.00
90.01	04951	WOUND CARE	51,045	0	90.01
91.00	09100	EMERGENCY	722,317	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	63,082	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	20,090	0	93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	4,001,679	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	4,001,679	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141323 | Component CCN: 14Z323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part V | Date/Time Prepared: 8/30/2016 8:31 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.486324	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.003463	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.105033	0	0	0	0	54.00
60.00	06000	LABORATORY	0.329535	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.543221	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.838457	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.161050	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6.464517	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.643413	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488194	0	0	0	0	73.00
76.00	03020	GERIATRIC PSYCH	1.040789	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.00
90.01	04951	WOUND CARE	0.764213	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.579371	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.881757	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.343304	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.310395		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141323 | Component CCN: 14Z323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part V | Date/Time Prepared: 8/30/2016 8:31 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	GERIATRIC PSYCH	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.00
90.01	04951	WOUND CARE	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D-1 | Date/Time Prepared: 8/30/2016 8:31 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,749	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,072	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)	2,913	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	243	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)	327	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	85	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)	22	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,411	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)	243	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)	327	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	132.61	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.61	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,437,752	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	11,272	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)	2,917	25.00
26.00	Total swing-bed cost (see instructions)	706,511	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,731,241	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)	3,731,241	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)	1,214.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,713,801	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)	1,713,801	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D-1 | Date/Time Prepared: 8/30/2016 8:31 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	955,455	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,669,256	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)	295,148	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	397,174	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	692,322	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)	159	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,214.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	193,121	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D-1 | Date/Time Prepared: 8/30/2016 8:31 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	635,493	4,437,752	0.143202	193,121	27,655	90.00
91.00	Nursing School cost	0	4,437,752	0.000000	193,121	0	91.00
92.00	Allied health cost	0	4,437,752	0.000000	193,121	0	92.00
93.00	All other Medical Education	0	4,437,752	0.000000	193,121	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D-3 | Date/Time Prepared: 8/30/2016 8:31 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,078,818		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.486324	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.003463	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.105033	609,759	64,045	54.00
60.00	06000	LABORATORY	0.329535	654,938	215,825	60.00
65.00	06500	RESPIRATORY THERAPY	0.543221	575,872	312,826	65.00
66.00	06600	PHYSICAL THERAPY	0.838457	7,380	6,188	66.00
69.00	06900	ELECTROCARDIOLOGY	0.161050	293,654	47,293	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6.464517	5,640	36,460	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.643413	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488194	554,429	270,669	73.00
76.00	03020	GERIATRIC PSYCH	1.040789	759	790	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.00
90.01	04951	WOUND CARE	0.764213	0	0	90.01
91.00	09100	EMERGENCY	0.579371	2,345	1,359	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.881757	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.343304	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		2,704,776	955,455	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		2,704,776		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141323 | Component CCN: 14Z323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D-3 | Date/Time Prepared: 8/30/2016 8:31 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.486324	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.003463	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.105033	52,201	5,483	54.00
60.00	06000	LABORATORY	0.329535	90,602	29,857	60.00
65.00	06500	RESPIRATORY THERAPY	0.543221	220,037	119,529	65.00
66.00	06600	PHYSICAL THERAPY	0.838457	77,858	65,281	66.00
69.00	06900	ELECTROCARDIOLOGY	0.161050	2,002	322	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6.464517	333	2,153	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.643413	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488194	176,697	86,262	73.00
76.00	03020	GERIATRIC PSYCH	1.040789	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.00
90.01	04951	WOUND CARE	0.764213	0	0	90.01
91.00	09100	EMERGENCY	0.579371	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.881757	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.343304	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		619,730	308,887	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)		619,730		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141323	Period: From 04/01/2015 To 03/31/2016	Worksheet E Part B Date/Time Prepared: 8/30/2016 8:31 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,001,679	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)	4,001,679	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)	4,041,696	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)	38,931	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,095,942	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,906,823	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,906,823	30.00
31.00	Primary payer payments	769	31.00
32.00	Subtotal (line 30 minus line 31)	1,906,054	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)	830,713	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	539,963	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	581,421	36.00
37.00	Subtotal (see instructions)	2,446,017	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,446,017	40.00
40.01	Sequestration adjustment (see instructions)	48,920	40.01
41.00	Interim payments	2,395,224	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	1,873	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: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 8/30/2016 8:31 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,320,218		2,227,941	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	11/09/2015	231,180	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	11/09/2015	274,832	03/29/2016	63,897	3.50
3.51		03/29/2016	573,763		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)		-848,595		167,283	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,471,623		2,395,224	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		1,873	6.01
6.02	SETTLEMENT TO PROGRAM		78,330		0	6.02
7.00	Total Medicare program liability (see instructions)		2,393,293		2,397,097	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: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 8/30/2016 8:31 am

Component CCN: 14Z323 | 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		893,618		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	11/09/2015	299,209		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	03/29/2016	174,707		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)		124,502		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)		1,018,120		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		33,631		0	6.02
7.00	Total Medicare program liability (see instructions)		984,489		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: 141323	Period: From 04/01/2015 To 03/31/2016	Worksheet E-1 Part II Date/Time Prepared: 8/30/2016 8:31 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	796	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,411	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	94	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,913	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	46,390,534	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	420,479	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: 141323 | Component CCN: 14Z323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet E-2 | Date/Time Prepared: 8/30/2016 8:31 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	699,245	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)	311,976	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	570	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)	1,011,221	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,011,221	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)	1,011,221	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,640	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)	1,004,581	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)	1,004,581	0	19.00
19.01	Sequestration adjustment (see instructions)	20,092	0	19.01
20.00	Interim payments	1,018,120	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)	-33,631	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: 141323	Period: From 04/01/2015 To 03/31/2016	Worksheet E-3 Part V Date/Time Prepared: 8/30/2016 8:31 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,669,256	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,669,256	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,695,949	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,695,949	19.00
20.00	Deductibles (exclude professional component)	346,119	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,349,830	22.00
23.00	Coinsurance	1,890	23.00
24.00	Subtotal (line 22 minus line 23)	2,347,940	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	144,917	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	94,196	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	108,614	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,442,136	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	2,442,136	30.00
30.01	Sequestration adjustment (see instructions)	48,843	30.01
31.00	Interim payments	2,471,623	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	-78,330	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet G | Date/Time Prepared: 8/30/2016 8:31 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	13,678,063	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	9,774,920	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,134,502	0	0	0	6.00
7.00	Inventory	402,200	0	0	0	7.00
8.00	Prepaid expenses	76,971	0	0	0	8.00
9.00	Other current assets	12,852	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)	16,810,504	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	65,980	0	0	0	12.00
13.00	Land improvements	1,075,420	0	0	0	13.00
14.00	Accumulated depreciation	-619,678	0	0	0	14.00
15.00	Buildings	16,978,332	0	0	0	15.00
16.00	Accumulated depreciation	-6,811,053	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	7,471,753	0	0	0	23.00
24.00	Accumulated depreciation	-4,533,193	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	424,784	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)	14,052,345	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,863,968	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	257,883	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,121,851	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	32,984,700	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	150,487	0	0	0	37.00
38.00	Salaries, wages, and fees payable	870,894	0	0	0	38.00
39.00	Payroll taxes payable	32,174	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,352,350	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,405,905	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,169,851	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)	10,169,851	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,575,756	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	19,408,944				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)	19,408,944	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	32,984,700	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet G-1 | Date/Time Prepared: 8/30/2016 8:31 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		18,513,106		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		895,838				2.00
3.00	Total (sum of line 1 and line 2)		19,408,944		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		19,408,944		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		19,408,944		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/30/2016 8:31 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,294,655		2,294,655	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	255,040		255,040	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)	2,549,695		2,549,695	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)	2,549,695		2,549,695	17.00
18.00	Ancillary services	7,366,188	34,486,372	41,852,560	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	847,332	847,332	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	1,710,106	1,710,106	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,915,883	37,043,810	46,959,693	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		21,498,096		29.00
30.00	BAD DEBT EXPENSE	133,504			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)		133,504		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		21,631,600		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141323	Period: From 04/01/2015 To 03/31/2016	Worksheet G-3 Date/Time Prepared: 8/30/2016 8:31 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	46,959,693	1.00
2.00	Less contractual allowances and discounts on patients' accounts	25,698,044	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,261,649	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,631,600	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-369,951	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	97,592	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	17,767	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	71,878	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	1,497	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	112,334	22.00
23.00	Governmental appropriations	198,483	23.00
24.00	OTHER OPERATING REVENUE	925,488	24.00
25.00	Total other income (sum of lines 6-24)	1,425,039	25.00
26.00	Total (line 5 plus line 25)	1,055,088	26.00
27.00	LOSS ON EQUITY INVESTMENT	159,250	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	159,250	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	895,838	29.00

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

Provider CCN: 141323 Component CCN: 143478 | Period: From 04/01/2015 To 03/31/2016 | Worksheet M-1 | Date/Time Prepared: 8/30/2016 8:31 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	316,827	0	316,827	0	316,827	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	203,046	0	203,046	0	203,046	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	29,041	0	29,041	0	29,041	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	548,914	0	548,914	0	548,914	10.00
11.00	Physician Services Under Agreement	167,869	0	167,869	0	167,869	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	225,576	225,576	0	225,576	13.00
14.00	Subtotal (sum of lines 11 through 13)	167,869	225,576	393,445	0	393,445	14.00
15.00	Medical Supplies	0	60,839	60,839	0	60,839	15.00
16.00	Transportation (Health Care Staff)	0	4,223	4,223	0	4,223	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	10,832	10,832	0	10,832	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	75,894	75,894	0	75,894	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	716,783	301,470	1,018,253	0	1,018,253	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	14,113	14,113	0	14,113	29.00
30.00	Administrative Costs	189,459	3,757	193,216	0	193,216	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	189,459	17,870	207,329	0	207,329	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	906,242	319,340	1,225,582	0	1,225,582	32.00

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

Provider CCN: 141323 | Component CCN: 143478 | Period: From 04/01/2015 To 03/31/2016 | Worksheet M-1 | Date/Time Prepared: 8/30/2016 8:31 am

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	316,827		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	203,046		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	29,041		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	548,914		10.00
11.00	Physician Services Under Agreement	0	167,869		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	225,576		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	393,445		14.00
15.00	Medical Supplies	0	60,839		15.00
16.00	Transportation (Health Care Staff)	0	4,223		16.00
17.00	Depreciation-Medical Equipment	6,017	6,017		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	10,832		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	6,017	81,911		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	6,017	1,024,270		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	14,113		29.00
30.00	Administrative Costs	-240	192,976		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-240	207,089		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	5,777	1,231,359		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141323 | Period: From 04/01/2015 To 03/31/2016 | Worksheet M-2

Component CCN: 143478 | Date/Time Prepared: 8/30/2016 8:31 am

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.37	4,213	4,200	9,954		1.00
2.00	Physician Assistant	1.82	5,964	2,100	3,822		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.19	10,177		13,776	13,776	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.19	10,177			13,776	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,024,270	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,024,270	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					207,089	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					991,876	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,198,965	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					1,198,965	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					1,198,965	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,223,235	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141323 Component CCN: 143478	Period: From 04/01/2015 To 03/31/2016	Worksheet M-3 Date/Time Prepared: 8/30/2016 8:31 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		2,223,235	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,223,235	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		13,776	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		13,776	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		161.38	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	80.44	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	161.38	161.38	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,993	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	321,630	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		321,630	16.00
16.01	Total program charges (see instructions)(from contractor's records)		177,951	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		500	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		904	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.)		250,013	16.04
16.05	Total program cost (see instructions)		250,917	16.05
17.00	Primary payer amounts		65	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,210	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		33,948	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		250,852	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		250,852	22.00
23.00	Allowable bad debts (see instructions)		13,281	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		8,633	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)		259,485	26.00
26.01	Sequestration adjustment (see instructions)		5,190	26.01
27.00	Interim payments		168,594	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)		85,701	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141323 Component CCN: 143478	Period: From 04/01/2015 To 03/31/2016	Worksheet M-5 Date/Time Prepared: 8/30/2016 8:31 am
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		168,063	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		10/16/2014	531	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		531	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		168,594	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		85,701	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		254,295	7.00

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