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: 141329	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 10/26/2016 10:31 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 10/26/2016 Time: 10:31 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 MORRISON COMMUNITY HOSPITAL (141329) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
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	10,153	37,194	-42,162	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	180,944	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-29,234		0	10.00
200.00	Total	0	191,097	7,960	-42,162	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: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 10/24/2016 4:27 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 303 JACKSON	PO Box:			1.00
2.00	City: MORRISON	State: IL	Zip Code: 61270	County: WHITESIDE	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	MORRISON COMMUNITY HOSPITAL	141329	99914	1	08/01/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MORRISON SWING BED	14Z329	99914		08/01/2003	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	MORRISON COMMUNITY HOSPITAL CLINIC	143981	99914		07/01/1996	N	O	O	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)	07/01/2015	06/30/2016	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.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
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: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 10/24/2016 4:27 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 10/24/2016 4:27 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 10/24/2016 4:27 pm

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

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

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

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

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

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	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:	339,509	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: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 10/24/2016 4:27 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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)	625,107	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: 141329	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 10/24/2016 4:27 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/03/2014	12/31/2014	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: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 10/24/2016 4:27 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/22/2016	Y	09/22/2016	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 10/24/2016 4:27 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	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.	Y	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.	DAN	LINHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-888-4404	DAN.LINHART@RSMUS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 10/24/2016 4:27 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 10/24/2016 4:27 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	4,200.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	4,200.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,150	4,200.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		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: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 10/24/2016 4:27 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	107	22	175			1.00
2.00	HMO and other (see instructions)	14	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	1,713	0	2,116			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	244			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,820	22	2,535			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)	1,820	22	2,535	0.00	105.01	14.00
15.00	CAH visits	2,077	1,111	5,930			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	2,017	5,189	16,298	0.00	16.76	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	121.77	27.00
28.00	Observation Bed Days		14	82			28.00
29.00	Ambulance Trips	293					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: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 10/24/2016 4:27 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	39	11	67	1.00
2.00	HMO and other (see instructions)			6	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	39	11	67	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: 141329 Component CCN: 143981 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-8 | Date/Time Prepared: 10/24/2016 4:27 pm

				Rural Health Clinic (RHC) I	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			300 NORTH JACKSON STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MORRISON		IL	61270	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	08:00	20:00	08:00	20:00	08:00	11.00

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

		Provider name	CCN number	
		1.00	2.00	
14.00	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		WHITESIDE				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	20:00	08:00	20:00	08:00	20:00	11.00

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

Provider CCN: 141329
Component CCN: 143981

Period: From 07/01/2015 To 06/30/2016

Worksheet S-8

Date/Time Prepared: 10/24/2016 4:27 pm

Rural Health Clinic (RHC) I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	20:00	08:00	20:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-10 | Date/Time Prepared: 10/24/2016 4:27 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.738274	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,117,372	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	3,104,109	6.00
7.00	Medicaid cost (line 1 times line 6)	2,291,683	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,174,311	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)	1,174,311	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	82,977	51,413	134,390	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	61,260	37,957	99,217	21.00
22.00	Partial payment by patients approved for charity care	6,490	1,936	8,426	22.00
23.00	Cost of charity care (line 21 minus line 22)	54,770	36,021	90,791	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,066,348	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	48,285	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,018,063	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	751,609	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	842,400	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,016,711	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 10/24/2016 4:27 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		674,790	674,790	-218,407	456,383	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		117,226	117,226	384,081	501,307	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,293,946	1,293,946	-111,327	1,182,619	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	35,531	294	35,825	0	35,825	5.01
5.02	00591	PERSONNEL	107,458	13,316	120,774	0	120,774	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	296,636	84,848	381,484	0	381,484	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	449,226	394,309	843,535	233,946	1,077,481	5.05
7.00	00700	OPERATION OF PLANT	126,013	348,360	474,373	0	474,373	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,670	26,670	0	26,670	8.00
9.00	00900	HOUSEKEEPING	156,976	23,861	180,837	0	180,837	9.00
10.00	01000	DIETARY	181,342	85,923	267,265	0	267,265	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	118,740	3,423	122,163	0	122,163	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,701	24,422	48,123	0	48,123	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	222,301	34,167	256,468	0	256,468	16.00
17.00	01700	SOCIAL SERVICE	70,630	951	71,581	0	71,581	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,204,026	202,096	1,406,122	-6,456	1,399,666	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	64,805	129,196	194,001	0	194,001	50.00
53.00	05300	ANESTHESIOLOGY	0	44,948	44,948	0	44,948	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	239,479	68,609	308,088	5,558	313,646	54.00
60.00	06000	LABORATORY	333,387	329,858	663,245	0	663,245	60.00
64.00	06400	INTRAVENOUS THERAPY	0	32,988	32,988	34,318	67,306	64.00
65.00	06500	RESPIRATORY THERAPY	238	35,475	35,713	-33,875	1,838	65.00
66.00	06600	PHYSICAL THERAPY	271,434	4,259	275,693	0	275,693	66.00
67.00	06700	OCCUPATIONAL THERAPY	202,285	1,442	203,727	0	203,727	67.00
68.00	06800	SPEECH PATHOLOGY	8,082	0	8,082	0	8,082	68.00
69.00	06900	ELECTROCARDIOLOGY	282	4,754	5,036	0	5,036	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,741	1,741	44,330	46,071	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,529	15,529	0	15,529	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	177,812	242,543	420,355	0	420,355	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,553,091	529,893	2,082,984	-9,754	2,073,230	88.00
91.00	09100	EMERGENCY	463,423	1,393,369	1,856,792	-201,956	1,654,836	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	18,888	9,555	28,443	0	28,443	93.00
93.01	04951	DIABETIC EDUCATION	38,711	960	39,671	0	39,671	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	54,121	37,557	91,678	-8,440	83,238	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		112,018	112,018	-112,018	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,418,618	6,323,296	12,741,914	0	12,741,914	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	5,500	5,500	0	5,500	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	6,418,618	6,328,796	12,747,414	0	12,747,414	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 10/24/2016 4:27 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-721	455,662		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-181,966	319,341		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,459	1,179,160		4.00
5.01	00560	PURCHASING RECEIVING AND STORES	0	35,825		5.01
5.02	00591	PERSONNEL	0	120,774		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	-14,555	366,929		5.03
5.05	00590	ADMINISTRATIVE & GENERAL	-22,753	1,054,728		5.05
7.00	00700	OPERATION OF PLANT	0	474,373		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,670		8.00
9.00	00900	HOUSEKEEPING	0	180,837		9.00
10.00	01000	DIETARY	-47,587	219,678		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	122,163		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	48,123		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,719	251,749		16.00
17.00	01700	SOCIAL SERVICE	0	71,581		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,399,666		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-31,710	162,291		50.00
53.00	05300	ANESTHESIOLOGY	-2,897	42,051		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-6,583	307,063		54.00
60.00	06000	LABORATORY	-31,197	632,048		60.00
64.00	06400	INTRAVENOUS THERAPY	-873	66,433		64.00
65.00	06500	RESPIRATORY THERAPY	-16	1,822		65.00
66.00	06600	PHYSICAL THERAPY	-6,457	269,236		66.00
67.00	06700	OCCUPATIONAL THERAPY	-7,400	196,327		67.00
68.00	06800	SPEECH PATHOLOGY	0	8,082		68.00
69.00	06900	ELECTROCARDIOLOGY	-4,417	619		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-3	46,068		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,529		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,626	418,729		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-60,738	2,012,492		88.00
91.00	09100	EMERGENCY	-159,372	1,495,464		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	WOUND CARE	0	28,443		93.00
93.01	04951	DIABETIC EDUCATION	0	39,671		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-4	83,234		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-589,053	12,152,861		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OPTH CLINIC	0	5,500		194.00
194.01	07951	RENTAL SPACE	0	0		194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-589,053	12,158,361		200.00

RECLASSIFICATIONS | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 10/24/2016 4:27 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	97,968		1.00
2.00	ADMINISTRATIVE & GENERAL	5.05	0	7,898		2.00
3.00	AMBULANCE SERVICES	95.00	0	594		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,558		4.00
	TOTALS		0	112,018		
	B - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	52,480		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	15,226		2.00
3.00	ADMINISTRATIVE & GENERAL	5.05	0	226,048		3.00
	TOTALS		0	293,754		
	C - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	368,855		1.00
	TOTALS		0	368,855		
	E - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	44,330		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	44,330		
	G - RHC PHYS IN ER					
1.00	RURAL HEALTH CLINIC	88.00	0	33,255		1.00
	TOTALS		0	33,255		
	H - IV THERAPY SALARIES					
1.00	INTRAVENOUS THERAPY	64.00	34,318	0		1.00
	TOTALS		34,318	0		
	I - PHYSICIAN BENEFITS					
1.00	RURAL HEALTH CLINIC	88.00	0	111,327		1.00
	TOTALS		0	111,327		
500.00	Grand Total: Increases		34,318	963,539		500.00

RECLASSIFICATIONS | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 10/24/2016 4:27 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	112,018	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	112,018			
	B - INSURANCE						
1.00	EMERGENCY	91.00	0	130,384	12		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	154,336	12		2.00
3.00	AMBULANCE SERVICES	95.00	0	9,034	0		3.00
	TOTALS		0	293,754			
	C - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	368,855	9		1.00
	TOTALS		0	368,855			
	E - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	6,456	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	33,875	0		2.00
3.00	EMERGENCY	91.00	0	3,999	0		3.00
	TOTALS		0	44,330			
	G - RHC PHYS IN ER						
1.00	EMERGENCY	91.00	0	33,255	0		1.00
	TOTALS		0	33,255			
	H - IV THERAPY SALARIES						
1.00	EMERGENCY	91.00	34,318	0	0		1.00
	TOTALS		34,318	0			
	I - PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	111,327	0		1.00
	TOTALS		0	111,327			
500.00	Grand Total: Decreases		34,318	963,539			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 10/24/2016 4:27 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	210,147	-188,490	0	-188,490	0	1.00
2.00	Land Improvements	362,300	11,872	0	11,872	0	2.00
3.00	Buildings and Fixtures	4,647,047	242,074	0	242,074	0	3.00
4.00	Building Improvements	3,679,351	793,283	0	793,283	0	4.00
5.00	Fixed Equipment	329,166	24,410	0	24,410	0	5.00
6.00	Movable Equipment	4,842,273	99,489	0	99,489	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,070,284	982,638	0	982,638	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	14,070,284	982,638	0	982,638	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	21,657	0	1.00
2.00	Land Improvements	374,172	0	2.00
3.00	Buildings and Fixtures	4,889,121	0	3.00
4.00	Building Improvements	4,472,634	0	4.00
5.00	Fixed Equipment	353,576	0	5.00
6.00	Movable Equipment	4,941,762	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,052,922	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	15,052,922	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 10/24/2016 4:27 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	674,790	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	117,226	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	792,016	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	674,790	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	117,226	2.00
3.00	Total (sum of lines 1-2)	0	792,016	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 10/24/2016 4:27 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	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	10,111,159	0	10,111,159	0.671707	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,941,762	0	4,941,762	0.328293	0	2.00
3.00	Total (sum of lines 1-2)	15,052,921	0	15,052,921	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	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	305,935	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	304,115	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	610,050	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	97,247	52,480	0	0	455,662	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	15,226	0	0	319,341	2.00
3.00	Total (sum of lines 1-2)	97,247	67,706	0	0	775,003	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 10/24/2016 4:27 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-721	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		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	-1,180	ADMINISTRATIVE & GENERAL	5.05	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	-201,050			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-41,926	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,719	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 10/24/2016 4:27 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-181,966	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	CATERING REVENUE	B	-5,170	DIETARY	10.00	0	33.00
33.01	LAB OTHER REVENUE	B	-19,447	LABORATORY	60.00	0	33.01
33.02	REHAB MISC REV	B	-5,480	PHYSICAL THERAPY	66.00	0	33.02
33.03	INVESTMENT INCOME-OTHER	B	-58	ADMINISTRATIVE & GENERAL	5.05	0	33.03
33.04	INVESTMENT INCOME-OTHER	B	-4	AMBULANCE SERVICES	95.00	0	33.04
33.05	INVESTMENT INCOME-OTHER	B	-41	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	OTHER REV -A&G	B	-2,956	ADMINISTRATIVE & GENERAL	5.05	0	33.06
33.07	OTHER REV - DIETARY	B	-491	DIETARY	10.00	0	33.07
33.08	OTHER REV - IT	B	-170	ADMINISTRATIVE & GENERAL	5.05	0	33.08
33.09	NONALLOWABLE DUES	B	-4,428	ADMINISTRATIVE & GENERAL	5.05	0	33.09
33.10	PATIENT TELEPHONE - SALARIES	A	-2,634	ADMINISTRATIVE & GENERAL	5.05	0	33.10
33.11	PATIENT TELEPHONE - BENEFITS	A	-530	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	PHYSICIAN BILLING SALARIES	A	-14,555	CASHIERING/ACCOUNTS RECEIVABLE	5.03	0	33.12
33.13	PHYSICIAN BILLING EMPLOYEE BENEFITS	A	-2,929	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	ADVERTISING	A	-11,244	ADMINISTRATIVE & GENERAL	5.05	0	33.14
33.15	OTHER REV- EDUCATION	A	-83	ADMINISTRATIVE & GENERAL	5.05	0	33.15
33.16	SELF INSURANCE EXPENSE	A	-15,897	OPERATING ROOM	50.00	0	33.16
33.17	SELF INSURANCE EXPENSE	A	-2,897	ANESTHESIOLOGY	53.00	0	33.17
33.18	SELF INSURANCE EXPENSE	A	-6,542	RADIOLOGY-DIAGNOSTIC	54.00	0	33.18
33.19	SELF INSURANCE EXPENSE	A	-11,750	LABORATORY	60.00	0	33.19
33.20	SELF INSURANCE EXPENSE	A	-873	INTRAVENOUS THERAPY	64.00	0	33.20
33.21	SELF INSURANCE EXPENSE	A	-16	RESPIRATORY THERAPY	65.00	0	33.21
33.22	SELF INSURANCE EXPENSE	A	-977	PHYSICAL THERAPY	66.00	0	33.22
33.23	SELF INSURANCE EXPENSE	A	-7,400	OCCUPATIONAL THERAPY	67.00	0	33.23
33.24	SELF INSURANCE EXPENSE	A	-32	ELECTROCARDIOLOGY	69.00	0	33.24
33.25	SELF INSURANCE EXPENSE	A	-3	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	33.25
33.26	SELF INSURANCE EXPENSE	A	-1,626	DRUGS CHARGED TO PATIENTS	73.00	0	33.26
33.27	SELF INSURANCE EXPENSE	A	-2,864	EMERGENCY	91.00	0	33.27
33.28	SELF INSURANCE EXPENSE	A	-36,394	RURAL HEALTH CLINIC	88.00	0	33.28
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-589,053				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: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 10/24/2016 4:27 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,138,688	156,508	982,180	0	0	1.00
2.00	91.00	EMERGENCY	9,450	0	9,450	0	0	2.00
3.00	50.00	OPERATING ROOM	15,813	15,813	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	4,385	4,385	0	0	0	4.00
5.00	88.00	RURAL HEALTH CLINIC	24,344	24,344	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,192,680	201,050	991,630		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	156,508		1.00
2.00	91.00	EMERGENCY	0	0	0	0		2.00
3.00	50.00	OPERATING ROOM	0	0	0	15,813		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	4,385		4.00
5.00	88.00	RURAL HEALTH CLINIC	0	0	0	24,344		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	201,050		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 10/24/2016 4:27 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	PURCHASING RECEIVING AND STORES	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	455,662	455,662				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	319,341		319,341			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,179,160	0	0	1,179,160		4.00
5.01	00560	PURCHASING RECEIVING AND STORES	35,825	15,385	0	7,910	59,120	5.01
5.02	00591	PERSONNEL	120,774	3,146	0	23,922	122	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	366,929	9,302	0	62,796	2,007	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	1,054,728	27,933	73,891	99,419	4,866	5.05
7.00	00700	OPERATION OF PLANT	474,373	95,110	3,869	28,053	1,642	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,670	12,111	0	0	0	8.00
9.00	00900	HOUSEKEEPING	180,837	5,056	0	34,946	243	9.00
10.00	01000	DIETARY	219,678	14,003	230	40,370	1,034	10.00
11.00	01100	CAFETERIA	0	5,392	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	122,163	5,592	0	26,496	608	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	48,123	4,728	0	5,276	2,129	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	251,749	12,039	578	49,488	1,399	16.00
17.00	01700	SOCIAL SERVICE	71,581	1,391	0	15,723	182	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,399,666	84,953	29,009	268,037	9,184	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	162,291	19,049	41,303	14,427	912	50.00
53.00	05300	ANESTHESIOLOGY	42,051	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	307,063	12,666	159,642	53,312	2,372	54.00
60.00	06000	LABORATORY	632,048	13,848	4,757	74,218	3,832	60.00
64.00	06400	INTRAVENOUS THERAPY	66,433	0	0	7,640	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,822	0	424	53	0	65.00
66.00	06600	PHYSICAL THERAPY	269,236	14,939	0	60,426	1,764	66.00
67.00	06700	OCCUPATIONAL THERAPY	196,327	4,501	0	45,032	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,082	182	0	1,799	0	68.00
69.00	06900	ELECTROCARDIOLOGY	619	0	1,680	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	46,068	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,529	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	418,729	4,401	0	39,584	365	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,012,492	50,755	1,420	99,836	11,071	88.00
91.00	09100	EMERGENCY	1,495,464	9,684	2,035	95,526	9,245	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	28,443	2,791	0	4,205	2,190	93.00
93.01	04951	DIABETIC EDUCATION	39,671	0	0	8,618	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	83,234	25,641	503	12,048	3,953	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,152,861	454,598	319,341	1,179,160	59,120	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	5,500	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	1,064	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,158,361	455,662	319,341	1,179,160	59,120	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 10/24/2016 4:27 pm

		Cost Center Description	PERSONNEL	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			5.02	5.03	5A.03	5.05	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL	147,964					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	6,994	448,028				5.03
5.05	00590	ADMINISTRATIVE & GENERAL	10,592	0	1,271,429	1,271,429		5.05
7.00	00700	OPERATION OF PLANT	2,971	0	606,018	70,774	676,792	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	38,781	4,529	26,894	8.00
9.00	00900	HOUSEKEEPING	3,701	0	224,783	26,251	11,226	9.00
10.00	01000	DIETARY	4,276	0	279,591	32,652	31,094	10.00
11.00	01100	CAFETERIA	0	0	5,392	630	11,973	11.00
13.00	01300	NURSING ADMINISTRATION	2,800	0	157,659	18,412	12,417	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	559	0	60,815	7,102	10,499	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,241	0	320,494	37,429	26,732	16.00
17.00	01700	SOCIAL SERVICE	1,665	0	90,542	10,574	3,089	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,389	37,288	1,856,526	216,814	188,644	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,528	17,168	256,678	29,976	42,299	50.00
53.00	05300	ANESTHESIOLOGY	0	1,467	43,518	5,082	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,646	58,389	599,090	69,965	28,126	54.00
60.00	06000	LABORATORY	7,861	67,535	804,099	93,907	30,750	60.00
64.00	06400	INTRAVENOUS THERAPY	809	21,958	96,840	11,309	0	64.00
65.00	06500	RESPIRATORY THERAPY	6	7,739	10,044	1,173	0	65.00
66.00	06600	PHYSICAL THERAPY	6,400	30,384	383,149	44,746	33,173	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,769	15,734	266,363	31,107	9,994	67.00
68.00	06800	SPEECH PATHOLOGY	191	805	11,059	1,292	404	68.00
69.00	06900	ELECTROCARDIOLOGY	7	3,111	5,417	633	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,320	51,388	6,001	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,910	17,439	2,037	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,192	45,798	513,069	59,919	9,772	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	36,616	75,794	2,287,984	267,202	112,704	88.00
91.00	09100	EMERGENCY	10,117	38,097	1,660,168	193,883	21,503	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04950	WOUND CARE	445	1,669	39,743	4,641	6,199	93.00
93.01	04951	DIABETIC EDUCATION	913	206	49,408	5,770	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,276	17,656	144,311	16,853	56,938	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	147,964	448,028	12,151,797	1,270,663	674,430	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	5,500	642	0	194.00
194.01	07951	RENTAL SPACE	0	0	1,064	124	2,362	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	147,964	448,028	12,158,361	1,271,429	676,792	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 10/24/2016 4:27 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	70,204					8.00
9.00	00900	HOUSEKEEPING	0	262,260				9.00
10.00	01000	DIETARY	0	1,742	345,079			10.00
11.00	01100	CAFETERIA	0	0	216,594	234,589		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,975	0	2,619	193,082	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,523	0	1,521	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,978	0	15,940	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,625	0	2,816	4,126	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,827	97,521	125,966	72,236	105,842	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,488	18,459	0	2,901	4,245	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,825	13,095	0	12,560	0	54.00
60.00	06000	LABORATORY	0	16,176	0	19,150	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	28	32	65.00
66.00	06600	PHYSICAL THERAPY	2,714	17,450	0	10,054	14,722	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,257	0	5,661	8,291	67.00
68.00	06800	SPEECH PATHOLOGY	0	212	0	197	290	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	28	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	4,312	0	5,998	8,775	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,793	57,618	0	47,199	0	88.00
91.00	09100	EMERGENCY	14,977	11,322	0	31,091	45,567	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	0	1,752	0	817	1,192	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	225	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,580	0	0	3,548	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	70,204	261,017	342,560	234,589	193,082	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	1,243	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	2,519	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	70,204	262,260	345,079	234,589	193,082	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 10/24/2016 4:27 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	85,460					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	407,573				16.00
17.00	01700	SOCIAL SERVICE	0	0	112,772			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	382	32,257	112,772	2,847,787	-35,501	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,105	16,810	0	426,961	0	50.00
53.00	05300	ANESTHESIOLOGY	0	1,269	0	49,869	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	50,510	0	776,171	0	54.00
60.00	06000	LABORATORY	0	58,422	0	1,022,504	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	18,995	0	127,144	35,501	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,694	0	17,971	0	65.00
66.00	06600	PHYSICAL THERAPY	0	26,284	0	532,292	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	13,611	0	340,284	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	697	0	14,151	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,624	0	9,702	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,602	0	61,991	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,652	0	21,128	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	39,618	0	641,463	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	24,759	68,873	0	2,874,132	0	88.00
91.00	09100	EMERGENCY	6,214	46,760	0	2,031,485	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.00	04950	WOUND CARE	0	1,444	0	55,788	0	93.00
93.01	04951	DIABETIC EDUCATION	0	178	0	55,581	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	15,273	0	238,503	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	85,460	407,573	112,772	12,144,907	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	6,142	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	4,793	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	2,519	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	85,460	407,573	112,772	12,158,361	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 10/24/2016 4:27 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00560	PURCHASING RECEIVING AND STORES			5.01
5.02	00591	PERSONNEL			5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.03
5.05	00590	ADMINISTRATIVE & GENERAL			5.05
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,812,286		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	426,961		50.00
53.00	05300	ANESTHESIOLOGY	49,869		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	776,171		54.00
60.00	06000	LABORATORY	1,022,504		60.00
64.00	06400	INTRAVENOUS THERAPY	162,645		64.00
65.00	06500	RESPIRATORY THERAPY	17,971		65.00
66.00	06600	PHYSICAL THERAPY	532,292		66.00
67.00	06700	OCCUPATIONAL THERAPY	340,284		67.00
68.00	06800	SPEECH PATHOLOGY	14,151		68.00
69.00	06900	ELECTROCARDIOLOGY	9,702		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,991		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,128		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	641,463		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	2,874,132		88.00
91.00	09100	EMERGENCY	2,031,485		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	WOUND CARE	55,788		93.00
93.01	04951	DIABETIC EDUCATION	55,581		93.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	238,503		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,144,907		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
194.00	07950	OPTH CLINIC	6,142		194.00
194.01	07951	RENTAL SPACE	4,793		194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	2,519		194.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	12,158,361		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 10/24/2016 4:27 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	0	15,385	0	15,385	0	5.01
5.02	00591	PERSONNEL	0	3,146	0	3,146	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	9,302	0	9,302	0	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	0	27,933	73,891	101,824	0	5.05
7.00	00700	OPERATION OF PLANT	0	95,110	3,869	98,979	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,111	0	12,111	0	8.00
9.00	00900	HOUSEKEEPING	0	5,056	0	5,056	0	9.00
10.00	01000	DIETARY	0	14,003	230	14,233	0	10.00
11.00	01100	CAFETERIA	0	5,392	0	5,392	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,592	0	5,592	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,728	0	4,728	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,039	578	12,617	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,391	0	1,391	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	84,953	29,009	113,962	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	19,049	41,303	60,352	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,666	159,642	172,308	0	54.00
60.00	06000	LABORATORY	0	13,848	4,757	18,605	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	424	424	0	65.00
66.00	06600	PHYSICAL THERAPY	0	14,939	0	14,939	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,501	0	4,501	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	182	0	182	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,680	1,680	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	4,401	0	4,401	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	50,755	1,420	52,175	0	88.00
91.00	09100	EMERGENCY	0	9,684	2,035	11,719	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04950	WOUND CARE	0	2,791	0	2,791	0	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	25,641	503	26,144	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	454,598	319,341	773,939	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	1,064	0	1,064	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	455,662	319,341	775,003	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 10/24/2016 4:27 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES	PERSONNEL	CASHIERING/ACCOUNTS RECEIVABLE	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			5.01	5.02	5.03	5.05	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES	15,385					5.01
5.02	00591	PERSONNEL	32	3,178				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	522	150	9,974			5.03
5.05	00590	ADMINISTRATIVE & GENERAL	1,266	227	0	103,317		5.05
7.00	00700	OPERATION OF PLANT	427	64	0	5,751	105,221	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	368	4,181	8.00
9.00	00900	HOUSEKEEPING	63	79	0	2,133	1,745	9.00
10.00	01000	DIETARY	269	92	0	2,653	4,834	10.00
11.00	01100	CAFETERIA	0	0	0	51	1,861	11.00
13.00	01300	NURSING ADMINISTRATION	158	60	0	1,496	1,931	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	554	12	0	577	1,632	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	364	112	0	3,041	4,156	16.00
17.00	01700	SOCIAL SERVICE	47	36	0	859	480	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,390	609	830	17,618	29,330	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	237	33	382	2,436	6,576	50.00
53.00	05300	ANESTHESIOLOGY	0	0	33	413	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	617	121	1,299	5,685	4,373	54.00
60.00	06000	LABORATORY	997	169	1,503	7,631	4,781	60.00
64.00	06400	INTRAVENOUS THERAPY	0	17	489	919	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	172	95	0	65.00
66.00	06600	PHYSICAL THERAPY	459	137	676	3,636	5,157	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	102	350	2,528	1,554	67.00
68.00	06800	SPEECH PATHOLOGY	0	4	18	105	63	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69	51	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	118	488	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	42	165	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	95	90	1,019	4,869	1,519	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,883	790	1,691	21,716	17,522	88.00
91.00	09100	EMERGENCY	2,406	217	848	15,755	3,343	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	570	10	37	377	964	93.00
93.01	04951	DIABETIC EDUCATION	0	20	5	469	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,029	27	393	1,370	8,852	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,385	3,178	9,974	103,255	104,854	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	52	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	10	367	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	15,385	3,178	9,974	103,317	105,221	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 10/24/2016 4:27 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,660					8.00
9.00	00900	HOUSEKEEPING	0	9,076				9.00
10.00	01000	DIETARY	0	60	22,141			10.00
11.00	01100	CAFETERIA	0	0	13,897	21,201		11.00
13.00	01300	NURSING ADMINISTRATION	0	68	0	237	9,542	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	191	0	137	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	241	0	1,441	0	16.00
17.00	01700	SOCIAL SERVICE	0	56	0	255	204	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,215	3,376	8,082	6,525	5,229	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	353	639	0	262	210	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	670	453	0	1,135	0	54.00
60.00	06000	LABORATORY	0	560	0	1,731	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3	2	65.00
66.00	06600	PHYSICAL THERAPY	644	604	0	909	728	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	182	0	512	410	67.00
68.00	06800	SPEECH PATHOLOGY	0	7	0	18	14	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3	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	149	0	542	434	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,849	1,994	0	4,266	0	88.00
91.00	09100	EMERGENCY	3,554	392	0	2,810	2,252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	0	61	0	74	59	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	20	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	375	0	0	321	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,660	9,033	21,979	21,201	9,542	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	43	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	162	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	16,660	9,076	22,141	21,201	9,542	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 10/24/2016 4:27 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,831					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,972				16.00
17.00	01700	SOCIAL SERVICE	0	0	3,328			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35	1,739	3,328	202,268	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,958	906	0	77,344	0	50.00
53.00	05300	ANESTHESIOLOGY	0	68	0	514	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,723	0	189,384	0	54.00
60.00	06000	LABORATORY	0	3,150	0	39,127	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,024	0	2,449	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	361	0	1,057	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,417	0	29,306	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	734	0	10,873	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	38	0	449	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	195	0	1,998	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	248	0	854	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	89	0	296	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,136	0	15,254	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,269	3,711	0	110,866	0	88.00
91.00	09100	EMERGENCY	569	2,521	0	46,386	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.00	04950	WOUND CARE	0	78	0	5,021	0	93.00
93.01	04951	DIABETIC EDUCATION	0	10	0	524	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	824	0	39,335	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,831	21,972	3,328	773,305	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	52	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	1,484	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	162	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,831	21,972	3,328	775,003	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 10/24/2016 4:27 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00560	PURCHASING RECEIVING AND STORES			5.01
5.02	00591	PERSONNEL			5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.03
5.05	00590	ADMINISTRATIVE & GENERAL			5.05
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	202,268		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	77,344		50.00
53.00	05300	ANESTHESIOLOGY	514		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	189,384		54.00
60.00	06000	LABORATORY	39,127		60.00
64.00	06400	INTRAVENOUS THERAPY	2,449		64.00
65.00	06500	RESPIRATORY THERAPY	1,057		65.00
66.00	06600	PHYSICAL THERAPY	29,306		66.00
67.00	06700	OCCUPATIONAL THERAPY	10,873		67.00
68.00	06800	SPEECH PATHOLOGY	449		68.00
69.00	06900	ELECTROCARDIOLOGY	1,998		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	854		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	296		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,254		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	110,866		88.00
91.00	09100	EMERGENCY	46,386		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	WOUND CARE	5,021		93.00
93.01	04951	DIABETIC EDUCATION	524		93.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	39,335		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	773,305		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
194.00	07950	OPTH CLINIC	52		194.00
194.01	07951	RENTAL SPACE	1,484		194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	162		194.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	775,003		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 10/24/2016 4:27 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASING RECEIVING AND STORES (PURCHASE ORDERS)	PERSONNEL (GROSS SALARIES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	50,113					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		304,115				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	5,296,805			4.00
5.01	00560	PURCHASING RECEIVING AND STORES	1,692	0	35,531	972		5.01
5.02	00591	PERSONNEL	346	0	107,458	2	6,275,629	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,023	0	282,081	33	296,636	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	3,072	70,368	446,592	80	449,226	5.05
7.00	00700	OPERATION OF PLANT	10,460	3,685	126,013	27	126,013	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,332	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	556	0	156,976	4	156,976	9.00
10.00	01000	DIETARY	1,540	219	181,342	17	181,342	10.00
11.00	01100	CAFETERIA	593	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	615	0	119,022	10	118,740	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	520	0	23,701	35	23,701	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,324	550	222,301	23	222,301	16.00
17.00	01700	SOCIAL SERVICE	153	0	70,630	3	70,630	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,343	27,626	1,204,026	151	1,204,026	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,095	39,334	64,805	15	64,805	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,393	152,030	239,479	39	239,479	54.00
60.00	06000	LABORATORY	1,523	4,530	333,387	63	333,387	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	34,318	0	34,318	64.00
65.00	06500	RESPIRATORY THERAPY	0	404	238	0	238	65.00
66.00	06600	PHYSICAL THERAPY	1,643	0	271,434	29	271,434	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	202,285	0	202,285	67.00
68.00	06800	SPEECH PATHOLOGY	20	0	8,082	0	8,082	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,600	0	0	282	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	484	0	177,812	6	177,812	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,582	1,352	448,467	182	1,553,091	88.00
91.00	09100	EMERGENCY	1,065	1,938	429,105	152	429,105	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	307	0	18,888	36	18,888	93.00
93.01	04951	DIABETIC EDUCATION	0	0	38,711	0	38,711	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,820	479	54,121	65	54,121	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	49,996	304,115	5,296,805	972	6,275,629	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	117	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	455,662	319,341	1,179,160	59,120	147,964	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.092691	1.050067	0.222617	60.823045	0.023578	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	15,385	3,178	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	15.828189	0.000506	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 10/24/2016 4:27 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (NON-NURSING HOME CH)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5.03	5A.05	5.05	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	16,585,723					5.03
5.05	00590	ADMINISTRATIVE & GENERAL	0	-1,271,429	10,886,932			5.05
7.00	00700	OPERATION OF PLANT	0	0	606,018	33,520		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	38,781	1,332	10,711	8.00
9.00	00900	HOUSEKEEPING	0	0	224,783	556	0	9.00
10.00	01000	DIETARY	0	0	279,591	1,540	0	10.00
11.00	01100	CAFETERIA	0	0	5,392	593	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	157,659	615	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	60,815	520	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	320,494	1,324	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	90,542	153	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,380,376	0	1,856,526	9,343	5,924	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	635,533	0	256,678	2,095	227	50.00
53.00	05300	ANESTHESIOLOGY	54,293	0	43,518	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,161,500	0	599,090	1,393	431	54.00
60.00	06000	LABORATORY	2,500,100	0	804,099	1,523	0	60.00
64.00	06400	INTRAVENOUS THERAPY	812,878	0	96,840	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	286,478	0	10,044	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,124,790	0	383,149	1,643	414	66.00
67.00	06700	OCCUPATIONAL THERAPY	582,458	0	266,363	495	0	67.00
68.00	06800	SPEECH PATHOLOGY	29,806	0	11,059	20	0	68.00
69.00	06900	ELECTROCARDIOLOGY	115,178	0	5,417	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	196,952	0	51,388	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	70,703	0	17,439	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,695,398	0	513,069	484	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,805,957	0	2,287,984	5,582	1,189	88.00
91.00	09100	EMERGENCY	1,410,303	0	1,660,168	1,065	2,285	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	61,801	0	39,743	307	0	93.00
93.01	04951	DIABETIC EDUCATION	7,613	0	49,408	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	653,606	0	144,311	2,820	241	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,585,723	-1,271,429	10,880,368	33,403	10,711	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	5,500	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	1,064	117	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	448,028		1,271,429	676,792	70,204	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.027013		0.116785	20.190692	6.554383	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,974		103,317	105,221	16,660	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000601		0.009490	3.139051	1.555410	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 10/24/2016 4:27 pm

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (# OF LOADS)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	24,693					9.00
10.00	01000	DIETARY	164	20,546				10.00
11.00	01100	CAFETERIA	0	12,896	8,330			11.00
13.00	01300	NURSING ADMINISTRATION	186	0	93	97,326		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	520	0	54	0	894	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	657	0	566	0	0	16.00
17.00	01700	SOCIAL SERVICE	153	0	100	2,080	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,182	7,500	2,565	53,351	4	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,738	0	103	2,140	566	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,233	0	446	0	0	54.00
60.00	06000	LABORATORY	1,523	0	680	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1	16	0	65.00
66.00	06600	PHYSICAL THERAPY	1,643	0	357	7,421	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	201	4,179	0	67.00
68.00	06800	SPEECH PATHOLOGY	20	0	7	146	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1	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	406	0	213	4,423	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,425	0	1,676	0	259	88.00
91.00	09100	EMERGENCY	1,066	0	1,104	22,969	65	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	165	0	29	601	0	93.00
93.01	04951	DIABETIC EDUCATION	0	0	8	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	126	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,576	20,396	8,330	97,326	894	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	117	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	150	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	262,260	345,079	234,589	193,082	85,460	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.620824	16.795435	28.161945	1.983869	95.592841	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,076	22,141	21,201	9,542	7,831	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.367554	1.077631	2.545138	0.098042	8.759508	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 10/24/2016 4:27 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (NON-NURSIN G HOME CH)	SOCIAL SERVICE (TIME SPENT)		
			16.00	17.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00560	PURCHASING RECEIVING AND STORES				5.01
5.02	00591	PERSONNEL				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.05	00590	ADMINISTRATIVE & GENERAL				5.05
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,441,541			16.00
17.00	01700	SOCIAL SERVICE	0	100		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,380,376	100		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	719,374	0		50.00
53.00	05300	ANESTHESIOLOGY	54,293	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,161,500	0		54.00
60.00	06000	LABORATORY	2,500,100	0		60.00
64.00	06400	INTRAVENOUS THERAPY	812,878	0		64.00
65.00	06500	RESPIRATORY THERAPY	286,478	0		65.00
66.00	06600	PHYSICAL THERAPY	1,124,790	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	582,458	0		67.00
68.00	06800	SPEECH PATHOLOGY	29,806	0		68.00
69.00	06900	ELECTROCARDIOLOGY	155,103	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	196,952	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	70,703	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,695,398	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	2,947,297	0		88.00
91.00	09100	EMERGENCY	2,001,015	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	WOUND CARE	61,801	0		93.00
93.01	04951	DIABETIC EDUCATION	7,613	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	653,606	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,441,541	100		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OPTH CLINIC	0	0		194.00
194.01	07951	RENTAL SPACE	0	0		194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0		194.02
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	407,573	112,772		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.023368	1,127.720000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	21,972	3,328		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001260	33.280000		205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-2 | Date/Time Prepared: 10/24/2016 4:27 pm

		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
7.00		IV THERAPY	1	30.00	-35,501	7.00
8.00		IV THERAPY	1	64.00	35,501	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 10/24/2016 4:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,812,286		2,812,286	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	426,961		426,961	0	0	50.00
53.00	05300	ANESTHESIOLOGY	49,869		49,869	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	776,171		776,171	0	0	54.00
60.00	06000	LABORATORY	1,022,504		1,022,504	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	162,645		162,645	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	17,971	0	17,971	0	0	65.00
66.00	06600	PHYSICAL THERAPY	532,292	0	532,292	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	340,284	0	340,284	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,151	0	14,151	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	9,702		9,702	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,991		61,991	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,128		21,128	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	641,463		641,463	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,874,132		2,874,132	0	0	88.00
91.00	09100	EMERGENCY	2,031,485		2,031,485	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	95,946		95,946		0	92.00
93.00	04950	WOUND CARE	55,788		55,788	0	0	93.00
93.01	04951	DIABETIC EDUCATION	55,581		55,581	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	238,503		238,503	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,240,853	0	12,240,853	0	0	200.00
201.00		Less Observation Beds	95,946		95,946		0	201.00
202.00		Total (see instructions)	12,144,907	0	12,144,907	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 10/24/2016 4:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,185,020		1,185,020			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	611,082	611,082	0.698697	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	51,209	51,209	0.973833	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	86,086	2,056,166	2,142,252	0.362315	0.000000	54.00
60.00	06000	LABORATORY	201,287	2,270,644	2,471,931	0.413646	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	125,881	683,790	809,671	0.200878	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	246,064	40,219	286,283	0.062774	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	621,596	501,156	1,122,752	0.474096	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	409,412	161,047	570,459	0.596509	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	14,080	15,726	29,806	0.474770	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	5,174	109,606	114,780	0.084527	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	157,165	39,775	196,940	0.314771	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	70,703	70,703	0.298827	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,187,640	503,185	1,690,825	0.379379	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	109,699	2,660,330	2,770,029			88.00
91.00	09100	EMERGENCY	109	1,408,189	1,408,298	1.442511	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	195,356	195,356	0.491134	0.000000	92.00
93.00	04950	WOUND CARE	7,990	53,811	61,801	0.902704	0.000000	93.00
93.01	04951	DIABETIC EDUCATION	0	7,613	7,613	7.300801	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	653,606	653,606	0.364903	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,357,203	12,093,213	16,450,416			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,357,203	12,093,213	16,450,416			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 10/24/2016 4:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
93.00	04950	WOUND CARE	0.000000	93.00
93.01	04951	DIABETIC EDUCATION	0.000000	93.01
		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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 10/24/2016 4:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,812,286		2,812,286	0	2,812,286	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	426,961		426,961	0	426,961	50.00
53.00	05300	ANESTHESIOLOGY	49,869		49,869	0	49,869	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	776,171		776,171	0	776,171	54.00
60.00	06000	LABORATORY	1,022,504		1,022,504	0	1,022,504	60.00
64.00	06400	INTRAVENOUS THERAPY	162,645		162,645	0	162,645	64.00
65.00	06500	RESPIRATORY THERAPY	17,971	0	17,971	0	17,971	65.00
66.00	06600	PHYSICAL THERAPY	532,292	0	532,292	0	532,292	66.00
67.00	06700	OCCUPATIONAL THERAPY	340,284	0	340,284	0	340,284	67.00
68.00	06800	SPEECH PATHOLOGY	14,151	0	14,151	0	14,151	68.00
69.00	06900	ELECTROCARDIOLOGY	9,702		9,702	0	9,702	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,991		61,991	0	61,991	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,128		21,128	0	21,128	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	641,463		641,463	0	641,463	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,874,132		2,874,132	0	2,874,132	88.00
91.00	09100	EMERGENCY	2,031,485		2,031,485	0	2,031,485	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	95,946		95,946		95,946	92.00
93.00	04950	WOUND CARE	55,788		55,788	0	55,788	93.00
93.01	04951	DIABETIC EDUCATION	55,581		55,581	0	55,581	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	238,503		238,503	0	238,503	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,240,853	0	12,240,853	0	12,240,853	200.00
201.00		Less Observation Beds	95,946		95,946		95,946	201.00
202.00		Total (see instructions)	12,144,907	0	12,144,907	0	12,144,907	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 10/24/2016 4:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,185,020		1,185,020			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	611,082	611,082	0.698697	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	51,209	51,209	0.973833	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	86,086	2,056,166	2,142,252	0.362315	0.000000	54.00
60.00	06000	LABORATORY	201,287	2,270,644	2,471,931	0.413646	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	125,881	683,790	809,671	0.200878	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	246,064	40,219	286,283	0.062774	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	621,596	501,156	1,122,752	0.474096	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	409,412	161,047	570,459	0.596509	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	14,080	15,726	29,806	0.474770	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	5,174	109,606	114,780	0.084527	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	157,165	39,775	196,940	0.314771	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	70,703	70,703	0.298827	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,187,640	503,185	1,690,825	0.379379	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	109,699	2,660,330	2,770,029	1.037582	0.000000	88.00
91.00	09100	EMERGENCY	109	1,408,189	1,408,298	1.442511	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	195,356	195,356	0.491134	0.000000	92.00
93.00	04950	WOUND CARE	7,990	53,811	61,801	0.902704	0.000000	93.00
93.01	04951	DIABETIC EDUCATION	0	7,613	7,613	7.300801	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	653,606	653,606	0.364903	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,357,203	12,093,213	16,450,416			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,357,203	12,093,213	16,450,416			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 10/24/2016 4:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
93.00	04950	WOUND CARE	0.000000	93.00
93.01	04951	DIABETIC EDUCATION	0.000000	93.01
		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: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 10/24/2016 4:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	77,344	611,082	0.126569	0	0	50.00
53.00	05300	ANESTHESIOLOGY	514	51,209	0.010037	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	189,384	2,142,252	0.088404	17,210	1,521	54.00
60.00	06000	LABORATORY	39,127	2,471,931	0.015829	32,562	515	60.00
64.00	06400	INTRAVENOUS THERAPY	2,449	809,671	0.003025	26,895	81	64.00
65.00	06500	RESPIRATORY THERAPY	1,057	286,283	0.003692	24,163	89	65.00
66.00	06600	PHYSICAL THERAPY	29,306	1,122,752	0.026102	5,177	135	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,873	570,459	0.019060	1,250	24	67.00
68.00	06800	SPEECH PATHOLOGY	449	29,806	0.015064	629	9	68.00
69.00	06900	ELECTROCARDIOLOGY	1,998	114,780	0.017407	597	10	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	854	196,940	0.004336	25,324	110	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	296	70,703	0.004187	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,254	1,690,825	0.009022	68,140	615	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	110,866	2,770,029	0.040023	0	0	88.00
91.00	09100	EMERGENCY	46,386	1,408,298	0.032938	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,901	195,356	0.035325	0	0	92.00
93.00	04950	WOUND CARE	5,021	61,801	0.081245	0	0	93.00
93.01	04951	DIABETIC EDUCATION	524	7,613	0.068830	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	538,603	14,611,790		201,947	3,109	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 10/24/2016 4:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
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
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04950	WOUND CARE	0	0	0	0	0	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		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: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 10/24/2016 4:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	611,082	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	51,209	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,142,252	0.000000	0.000000	17,210	54.00
60.00	06000	LABORATORY	0	2,471,931	0.000000	0.000000	32,562	60.00
64.00	06400	INTRAVENOUS THERAPY	0	809,671	0.000000	0.000000	26,895	64.00
65.00	06500	RESPIRATORY THERAPY	0	286,283	0.000000	0.000000	24,163	65.00
66.00	06600	PHYSICAL THERAPY	0	1,122,752	0.000000	0.000000	5,177	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	570,459	0.000000	0.000000	1,250	67.00
68.00	06800	SPEECH PATHOLOGY	0	29,806	0.000000	0.000000	629	68.00
69.00	06900	ELECTROCARDIOLOGY	0	114,780	0.000000	0.000000	597	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	196,940	0.000000	0.000000	25,324	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	70,703	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,690,825	0.000000	0.000000	68,140	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,770,029	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	1,408,298	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	195,356	0.000000	0.000000	0	92.00
93.00	04950	WOUND CARE	0	61,801	0.000000	0.000000	0	93.00
93.01	04951	DIABETIC EDUCATION	0	7,613	0.000000	0.000000	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	14,611,790			201,947	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 10/24/2016 4:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
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
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
93.00	04950	WOUND CARE	0	0	0		93.00
93.01	04951	DIABETIC EDUCATION	0	0	0		93.01
		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: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 10/24/2016 4:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.698697	0	240,095	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.973833	0	21,166	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.362315	0	520,012	0	0	54.00
60.00	06000	LABORATORY	0.413646	0	569,182	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.200878	0	200,927	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.062774	0	12,163	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.474096	0	179,193	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.596509	0	71,601	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.474770	0	12,033	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.084527	0	43,243	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.314771	0	17,640	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.298827	0	57,892	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379379	0	119,914	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	1.442511	0	373,762	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.491134	0	65,508	0	0	92.00
93.00	04950	WOUND CARE	0.902704	0	32,087	0	0	93.00
93.01	04951	DIABETIC EDUCATION	7.300801	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.364903		0			95.00
200.00		Subtotal (see instructions)		0	2,536,418	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	2,536,418	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 10/24/2016 4:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	167,754	0		50.00
53.00	05300	ANESTHESIOLOGY	20,612	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	188,408	0		54.00
60.00	06000	LABORATORY	235,440	0		60.00
64.00	06400	INTRAVENOUS THERAPY	40,362	0		64.00
65.00	06500	RESPIRATORY THERAPY	764	0		65.00
66.00	06600	PHYSICAL THERAPY	84,955	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	42,711	0		67.00
68.00	06800	SPEECH PATHOLOGY	5,713	0		68.00
69.00	06900	ELECTROCARDIOLOGY	3,655	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,553	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,300	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,493	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	539,156	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	32,173	0		92.00
93.00	04950	WOUND CARE	28,965	0		93.00
93.01	04951	DIABETIC EDUCATION	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	1,459,014	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	1,459,014	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141329 | Component CCN: 14Z329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 10/24/2016 4:27 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.698697	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.973833	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.362315	0	0	0	0	54.00
60.00	06000	LABORATORY	0.413646	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.200878	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.062774	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.474096	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.596509	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.474770	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.084527	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.314771	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.298827	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379379	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	1.442511	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.491134	0	0	0	0	92.00
93.00	04950	WOUND CARE	0.902704	0	0	0	0	93.00
93.01	04951	DIABETIC EDUCATION	7.300801	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.364903		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: 141329 | Component CCN: 14Z329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 10/24/2016 4:27 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04950	WOUND CARE	0	0		93.00
93.01	04951	DIABETIC EDUCATION	0	0		93.01
		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: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 10/24/2016 4:27 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,617	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	257	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)	175	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,058	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)	1,058	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	122	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)	122	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	107	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)	857	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)	856	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	144.67	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.50	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,812,286	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)	17,650	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)	17,995	25.00
26.00	Total swing-bed cost (see instructions)	2,511,577	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	300,709	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)	300,709	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)	1,170.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	125,201	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)	125,201	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 10/24/2016 4:27 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	63,995	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	189,196	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	1,002,776	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,001,606	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	2,004,382	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)	82	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,170.07	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	95,946	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 10/24/2016 4:27 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	202,268	2,812,286	0.071923	95,946	6,901	90.00
91.00	Nursing School cost	0	2,812,286	0.000000	95,946	0	91.00
92.00	Allied health cost	0	2,812,286	0.000000	95,946	0	92.00
93.00	All other Medical Education	0	2,812,286	0.000000	95,946	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 10/24/2016 4:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		98,815		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.698697	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.973833	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.362315	17,210	6,235	54.00
60.00	06000	LABORATORY	0.413646	32,562	13,469	60.00
64.00	06400	INTRAVENOUS THERAPY	0.200878	26,895	5,403	64.00
65.00	06500	RESPIRATORY THERAPY	0.062774	24,163	1,517	65.00
66.00	06600	PHYSICAL THERAPY	0.474096	5,177	2,454	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.596509	1,250	746	67.00
68.00	06800	SPEECH PATHOLOGY	0.474770	629	299	68.00
69.00	06900	ELECTROCARDIOLOGY	0.084527	597	50	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.314771	25,324	7,971	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.298827	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379379	68,140	25,851	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	1.442511	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.491134	0	0	92.00
93.00	04950	WOUND CARE	0.902704	0	0	93.00
93.01	04951	DIABETIC EDUCATION	7.300801	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		201,947	63,995	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)		201,947		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3

Component CCN: 14Z329 | Date/Time Prepared: 10/24/2016 4:27 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.698697	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.973833	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.362315	30,391	11,011	54.00
60.00	06000	LABORATORY	0.413646	111,807	46,249	60.00
64.00	06400	INTRAVENOUS THERAPY	0.200878	65,789	13,216	64.00
65.00	06500	RESPIRATORY THERAPY	0.062774	165,826	10,410	65.00
66.00	06600	PHYSICAL THERAPY	0.474096	460,517	218,329	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.596509	302,361	180,361	67.00
68.00	06800	SPEECH PATHOLOGY	0.474770	7,678	3,645	68.00
69.00	06900	ELECTROCARDIOLOGY	0.084527	3,184	269	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.314771	108,125	34,035	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.298827	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379379	835,432	316,945	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	1.442511	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.491134	0	0	92.00
93.00	04950	WOUND CARE	0.902704	0	0	93.00
93.01	04951	DIABETIC EDUCATION	7.300801	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		2,091,110	834,470	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)		2,091,110		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141329	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 10/24/2016 4:27 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,459,014	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)	1,459,014	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)	1,473,604	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)	3,893	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	394,548	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)	1,075,163	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)	1,075,163	30.00
31.00	Primary payer payments	74	31.00
32.00	Subtotal (line 30 minus line 31)	1,075,089	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)	28,881	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	18,773	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	25,423	36.00
37.00	Subtotal (see instructions)	1,093,862	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)	1,093,862	40.00
40.01	Sequestration adjustment (see instructions)	21,877	40.01
41.00	Interim payments	1,034,791	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	37,194	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: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 10/24/2016 4:27 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		136,099		1,125,470	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	06/16/2016	9,280		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	01/19/2016	43,930	3.50
3.51			0	06/16/2016	46,749	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)		9,280		-90,679	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)		145,379		1,034,791	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		10,153		37,194	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		155,532		1,071,985	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: 141329 | Component CCN: 14Z329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 10/24/2016 4:27 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,411,057		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	06/16/2016	179,641		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	01/19/2016	24,079		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)		155,562		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)		2,566,619		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		180,944		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,747,563		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: 141329	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 10/24/2016 4:27 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	67	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	107	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	14	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	175	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	16,450,416	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	134,390	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	625,107	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	560,783	8.00
9.00	Sequestration adjustment amount (see instructions)	11,216	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	549,567	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	591,729	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)	-42,162	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141329 | Component CCN: 14Z329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-2 | Date/Time Prepared: 10/24/2016 4:27 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	2,024,426	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)	842,815	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	1,713	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)	2,867,241	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,867,241	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)	2,867,241	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	71,516	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)	2,795,725	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)	12,170	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	7,911	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,170	0	18.00
19.00	Total (see instructions)	2,803,636	0	19.00
19.01	Sequestration adjustment (see instructions)	56,073	0	19.01
20.00	Interim payments	2,566,619	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)	180,944	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: 141329	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part V Date/Time Prepared: 10/24/2016 4:27 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	189,196	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)	189,196	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	191,088	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)	191,088	19.00
20.00	Deductibles (exclude professional component)	38,055	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	153,033	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	153,033	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	8,727	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	5,673	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	6,087	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	158,706	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)	158,706	30.00
30.01	Sequestration adjustment (see instructions)	3,174	30.01
31.00	Interim payments	145,379	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)	10,153	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: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G | Date/Time Prepared: 10/24/2016 4:27 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,045,054	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	2,691,186	0	0	0	4.00
5.00	Other receivable	955,460	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	216,916	0	0	0	7.00
8.00	Prepaid expenses	214,175	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,122,791	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	21,657	0	0	0	12.00
13.00	Land improvements	374,172	0	0	0	13.00
14.00	Accumulated depreciation	-280,044	0	0	0	14.00
15.00	Buildings	9,401,495	0	0	0	15.00
16.00	Accumulated depreciation	-5,347,058	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	5,295,339	0	0	0	23.00
24.00	Accumulated depreciation	-4,193,667	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	5,271,894	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	182,001	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	182,001	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	10,576,686	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	576,516	0	0	0	37.00
38.00	Salaries, wages, and fees payable	598,747	0	0	0	38.00
39.00	Payroll taxes payable	43,749	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,007,979	0	0	0	40.00
41.00	Deferred income	546,000	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	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,772,991	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,970,571	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,970,571	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,743,562	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	4,833,124				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)	4,833,124	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	10,576,686	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-1 | Date/Time Prepared: 10/24/2016 4:27 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		4,907,075		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-154,801				2.00
3.00	Total (sum of line 1 and line 2)		4,752,274		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	FOUNDATION	80,850		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)		80,850		0		10.00
11.00	Subtotal (line 3 plus line 10)		4,833,124		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)		4,833,124		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	FOUNDATION		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: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 10/24/2016 4:27 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	365,993		365,993	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,004,374		1,004,374	5.00
6.00	Swing bed - NF	20,713		20,713	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,391,080		1,391,080	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,391,080		1,391,080	17.00
18.00	Ancillary services	3,046,902	7,331,581	10,378,483	18.00
19.00	Outpatient services	8,099	2,062,975	2,071,074	19.00
20.00	RURAL HEALTH CLINIC	109,699	2,837,598	2,947,297	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	653,606	653,606	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NRCC	0	5,480	5,480	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,555,780	12,891,240	17,447,020	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		12,747,414		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		12,747,414		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141329 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-3 | Date/Time Prepared: 10/24/2016 4:27 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	17,447,020	1.00
2.00	Less contractual allowances and discounts on patients' accounts	6,118,128	2.00
3.00	Net patient revenues (line 1 minus line 2)	11,328,892	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	12,747,414	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,418,522	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	13,523	6.00
7.00	Income from investments	8,927	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	134,024	24.00
24.01	COUNTY TAX REVENUE	1,039,905	24.01
24.02	STATE TAX REVENUE	74,908	24.02
24.03	ROUNDING	0	24.03
25.00	Total other income (sum of lines 6-24)	1,271,287	25.00
26.00	Total (line 5 plus line 25)	-147,235	26.00
27.00		0	27.00
27.01	CHARITY CARE	7,566	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	7,566	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-154,801	29.00

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

Provider CCN: 141329 Component CCN: 143981 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-1 | Date/Time Prepared: 10/24/2016 4:27 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	937,790	0	937,790	0	937,790	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	110,892	0	110,892	0	110,892	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	55,942	0	55,942	0	55,942	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	448,467	0	448,467	0	448,467	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,553,091	0	1,553,091	0	1,553,091	10.00
11.00	Physician Services Under Agreement	0	250,323	250,323	33,255	283,578	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	250,323	250,323	33,255	283,578	14.00
15.00	Medical Supplies	0	32,336	32,336	0	32,336	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	154,336	154,336	-154,336	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	186,672	186,672	-154,336	32,336	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,553,091	436,995	1,990,086	-121,081	1,869,005	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	12,847	12,847	0	12,847	29.00
30.00	Administrative Costs	0	80,051	80,051	111,327	191,378	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	92,898	92,898	111,327	204,225	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,553,091	529,893	2,082,984	-9,754	2,073,230	32.00

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

Provider CCN: 141329 | Component CCN: 143981 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-1 | Date/Time Prepared: 10/24/2016 4:27 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	937,790		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-24,344	86,548		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	55,942		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	448,467		9.00
10.00	Subtotal (sum of lines 1 through 9)	-24,344	1,528,747		10.00
11.00	Physician Services Under Agreement	0	283,578		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	283,578		14.00
15.00	Medical Supplies	0	32,336		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	32,336		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-24,344	1,844,661		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	12,847		29.00
30.00	Administrative Costs	-36,394	154,984		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-36,394	167,831		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-60,738	2,012,492		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141329 | Component CCN: 143981 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-2 | Date/Time Prepared: 10/24/2016 4:27 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	3.89	13,226	4,200	16,338		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.62	1,841	2,100	1,302		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.51	15,067		17,640	17,640	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	0.80	1,231			1,231	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)	5.31	16,298			18,871	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)					1,844,661	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)					1,844,661	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)					167,831	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					861,640	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,029,471	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					1,029,471	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					1,029,471	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,874,132	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141329 | Component CCN: 143981 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-3 | Date/Time Prepared: 10/24/2016 4:27 pm

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		2,874,132	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		12,170	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,861,962	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		18,871	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)		18,871	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		151.66	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions)	151.66	151.66	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,931	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	292,855	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	86	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	13,043	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	13,043	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) *		305,898	16.00
16.01	Total program charges (see instructions)(from contractor's records)		375,622	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,543	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,257	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.)		225,718	16.04
16.05	Total program cost (see instructions)		226,975	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		22,493	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		69,849	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		226,975	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,486	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		228,461	22.00
23.00	Allowable bad debts (see instructions)		24,504	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		15,928	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		23,911	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)		244,389	26.00
26.01	Sequestration adjustment (see instructions)		4,888	26.01
27.00	Interim payments		268,735	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)		-29,234	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141329 | Component CCN: 143981 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-4 | Date/Time Prepared: 10/24/2016 4:27 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,528,747	1,528,747	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000167	0.000612	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	255	936	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	5,045	1,575	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	5,300	2,511	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,844,661	1,844,661	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	1,029,471	1,029,471	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002873	0.001361	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,958	1,401	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	8,258	3,912	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	35	128	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	235.94	30.56	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	5	10	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,180	306	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		12,170	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		1,486	16.00

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

Provider CCN: 141329 | Component CCN: 143981 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-5 | Date/Time Prepared: 10/24/2016 4:27 pm

Rural Health Clinic (RHC) I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		215,600	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		01/19/2016	13,497	3.01
3.02		06/16/2016	39,638	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)		53,135	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		268,735	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		29,234	6.02
7.00	Total Medicare program liability (see instructions)		239,501	7.00

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