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

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1342	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/30/2017 1:00 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/30/2017 Time: 1:00 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by UNION COUNTY HOSPITAL DISTRICT (14-1342) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	46,273	-484,214	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	99,982	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		10,925		0	10.00
200.00	Total	0	146,255	-473,289	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2017 11:51 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 517 NORTH MAIN STREET	PO Box:			1.00
2.00	City: ANNA	State: IL	Zip Code: 62906	County: UNION	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	UNION COUNTY HOSPITAL DISTRICT	141342	99914	1	07/01/1966	N	O	P	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	UNION COUNTY HOSP DIST SWING BEDS	14Z342	99914		08/05/1992	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	UNION COUNTY HOSP DIST RHC	143975	99914		05/22/1991	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2016	12/31/2016	20.00
21.00	Type of Control (see instructions)	4		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		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 11:51 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			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)				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: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 11:51 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 11:51 am

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

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

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	9,307	1,041,673	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: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2017 11:51 am

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0776	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: QUORUM HEALTH CORPORATION	Contractor's Name: WISCONSIN PHYSICAN SERVICES	Contractor's Number: 52280	141.00
142.00	Street: 1573 MALLORY LANE	PO Box: SUITE 100		142.00
143.00	City: BRENTWOOD	State: TN	Zip Code: 37027	143.00

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

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

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

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

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	1.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1342	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 11:51 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2016	09/28/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2017 11:51 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/01/2017	Y	03/01/2017
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 11:51 am

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	AMBER	WALKER	41.00
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-221-3646	AMBER_WALKER@QUORUMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1342	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 11:51 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2017 11:51 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	44,568.00	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	44,568.00	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	44,568.00	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	46.00	22	8,052			21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		47				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2017 11:51 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,219	209	1,857			1.00
2.00	HMO and other (see instructions)	201	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	883	0	883			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	338			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,102	209	3,078			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)	2,102	209	3,078	0.00	127.95	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			6,264	0.00	17.26	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	764	0	7,801	0.00	6.48	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	151.69	27.00
28.00	Observation Bed Days		0	312			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2017 11:51 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	331	75	534	1.00
2.00	HMO and other (see instructions)			55	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	331	75	534	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	0.00				0	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1342 | Component CCN: 14-3975 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-8 | Date/Time Prepared: 5/30/2017 11:51 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			517 NORTH MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ANNA		IL	62906	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic	12:00	17:00	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?					12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN number	
				1.00	2.00	
14.00	RHC/FQHC name, CCN number					14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		UNION				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 RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1342
Component CCN: 14-3975

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

Worksheet S-8
Date/Time Prepared:
5/30/2017 11:51 am

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: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/30/2017 11:51 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.223422	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,714,087	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	3,234,039	5.00
6.00	Medicaid charges	21,193,654	6.00
7.00	Medicaid cost (line 1 times line 6)	4,735,129	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)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	242,286	9.00
10.00	Stand-alone CHIP charges	2,469,999	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	551,852	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	309,566	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	309,566	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	80,996	57,392	138,388	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	18,096	12,823	30,919	21.00
22.00	Partial payment by patients approved for charity care	0	130	130	22.00
23.00	Cost of charity care (line 21 minus line 22)	18,096	12,693	30,789	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)	478,145	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	594,544	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	-116,399	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	-26,006	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,783	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	314,349	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/30/2017 11:51 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		170,609	170,609	82,644	253,253	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,434,949	1,434,949	655,312	2,090,261	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	96,256	26,962	123,218	1,564,951	1,688,169	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,343,895	4,797,105	6,141,000	-2,121,064	4,019,936	5.00
7.00	00700	OPERATION OF PLANT	255,458	694,545	950,003	-1,910	948,093	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,831	3,833	34,664	0	34,664	8.00
9.00	00900	HOUSEKEEPING	217,236	80,696	297,932	0	297,932	9.00
10.00	01000	DIETARY	213,079	233,912	446,991	0	446,991	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	763,208	56,478	819,686	34,620	854,306	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	94,234	128,047	222,281	-95,221	127,060	14.00
15.00	01500	PHARMACY	301,739	543,540	845,279	-467,199	378,080	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	95,692	106,352	202,044	-22,466	179,578	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	726,370	756,466	1,482,836	-647	1,482,189	30.00
46.00	04600	OTHER LONG TERM CARE	622,235	125,387	747,622	-729	746,893	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	240,193	117,339	357,532	26,357	383,889	50.00
51.00	05100	RECOVERY ROOM	16,994	5,780	22,774	-22,774	0	51.00
53.00	05300	ANESTHESIOLOGY	0	276,418	276,418	0	276,418	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	300,339	204,131	504,470	467,752	972,222	54.00
54.01	05401	ULTRASOUND	69,107	23,709	92,816	-92,816	0	54.01
56.00	05600	RADIOISOTOPE	0	102,159	102,159	-102,159	0	56.00
57.00	05700	CT SCAN	0	74,162	74,162	-74,162	0	57.00
58.00	05800	MRI	78,839	335,167	414,006	-414,006	0	58.00
60.00	06000	LABORATORY	352,652	382,879	735,531	-37,415	698,116	60.00
65.00	06500	RESPIRATORY THERAPY	45,828	34,230	80,058	-27,544	52,514	65.00
66.00	06600	PHYSICAL THERAPY	479,133	81,455	560,588	-1,454	559,134	66.00
67.00	06700	OCCUPATIONAL THERAPY	137,337	12,016	149,353	0	149,353	67.00
68.00	06800	SPEECH PATHOLOGY	84,457	6,406	90,863	0	90,863	68.00
69.00	06900	ELECTROCARDIOLOGY	66,115	14,890	81,005	0	81,005	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	118,093	118,093	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,003	1,003	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	448,011	448,011	73.00
76.00	03020	SLEEP LAB	0	95,650	95,650	0	95,650	76.00
76.03	03950	WOUND CARE	7,742	2,250	9,992	0	9,992	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	378,528	193,546	572,074	-36,472	535,602	88.00
91.00	09100	EMERGENCY	859,889	1,194,848	2,054,737	-1,084	2,053,653	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,877,386	12,315,916	20,193,302	-120,379	20,072,923	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	55,373	55,373	0	55,373	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	0	0	120,379	120,379	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	2,862	2,862	0	2,862	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	LEASED TO RURAL HEALTH ASSOCIATES	0	0	0	0	0	194.05
200.00		TOTAL (SUM OF LINES 118-199)	7,877,386	12,374,151	20,251,537	0	20,251,537	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/30/2017 11:51 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	526,023	779,276		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-870,476	1,219,785		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-508	1,687,661		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	577,604	4,597,540		5.00
7.00	00700	OPERATION OF PLANT	-3,763	944,330		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	34,664		8.00
9.00	00900	HOUSEKEEPING	0	297,932		9.00
10.00	01000	DIETARY	-24,779	422,212		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	854,306		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	127,060		14.00
15.00	01500	PHARMACY	0	378,080		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-345	179,233		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-634,077	848,112		30.00
46.00	04600	OTHER LONG TERM CARE	0	746,893		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	383,889		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	276,418		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	972,222		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	698,116		60.00
65.00	06500	RESPIRATORY THERAPY	0	52,514		65.00
66.00	06600	PHYSICAL THERAPY	0	559,134		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	149,353		67.00
68.00	06800	SPEECH PATHOLOGY	0	90,863		68.00
69.00	06900	ELECTROCARDIOLOGY	0	81,005		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	118,093		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,003		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	448,011		73.00
76.00	03020	SLEEP LAB	0	95,650		76.00
76.03	03950	WOUND CARE	0	9,992		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	535,602		88.00
91.00	09100	EMERGENCY	-565,050	1,488,603		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-995,371	19,077,552		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	55,373		192.00
194.00	07956	AREAS UNDER RENOVATION	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	120,379		194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	2,862		194.02
194.03	07953	FREESTANDING HHA COSTS	0	0		194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0		194.04
194.05	07955	LEASED TO RURAL HEALTH ASSOCIATES	0	0		194.05
200.00		TOTAL (SUM OF LINES 118-199)	-995,371	19,256,166		200.00

RECLASSIFICATIONS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/30/2017 11:51 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,564,951		1.00
	TOTALS		0	1,564,951		
	B - OXYGEN					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	27,544		1.00
	TOTALS		0	27,544		
	C - RENTAL AND LEASE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	316,157		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
	TOTALS		0	316,157		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	22,584		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	60,060		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,289		3.00
	TOTALS		0	84,933		
	E - MARKETING DEPT					
1.00	OTHER NONREIMBURSABLE - MARKETING	194.01	70,228	50,151		1.00
	TOTALS		70,228	50,151		
	F - MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	90,549		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,003		2.00
3.00	OPERATING ROOM	50.00	0	3,669		3.00
	TOTALS		0	95,221		
	G - COST OF DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	448,011		1.00
	TOTALS		0	448,011		
	I - AMORT EXP					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	336,866		1.00
	TOTALS		0	336,866		
	J - OTHER RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	147,946	535,197		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		147,946	535,197		
	K - RECOVERY ROOM					
1.00	OPERATING ROOM	50.00	16,994	5,780		1.00
	TOTALS		16,994	5,780		
	M - RHC SALARY TO ADMIN					
1.00	ADMINISTRATIVE & GENERAL	5.00	34,750	0		1.00
	TOTALS		34,750	0		
	N - INFECTION CONTROL					
1.00	NURSING ADMINISTRATION	13.00	27,874	6,746		1.00
	TOTALS		27,874	6,746		
500.00	Grand Total: Increases		297,792	3,471,557		500.00

RECLASSIFICATIONS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/30/2017 11:51 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,564,951	0		1.00
	TOTALS		0	1,564,951			
	B - OXYGEN						
1.00	RESPIRATORY THERAPY	65.00	0	27,544	0		1.00
	TOTALS		0	27,544			
	C - RENTAL AND LEASE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14,065	10		1.00
2.00	OPERATION OF PLANT	7.00	0	1,910	0		2.00
3.00	PHARMACY	15.00	0	19,188	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	22,466	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	647	0		5.00
6.00	OTHER LONG TERM CARE	46.00	0	729	0		6.00
7.00	OPERATING ROOM	50.00	0	86	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	215,391	0		8.00
9.00	LABORATORY	60.00	0	37,415	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	1,454	0		10.00
11.00	RURAL HEALTH CLINIC	88.00	0	1,722	0		11.00
12.00	EMERGENCY	91.00	0	1,084	0		12.00
	TOTALS		0	316,157			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	84,933	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	84,933			
	E - MARKETING DEPT						
1.00	ADMINISTRATIVE & GENERAL	5.00	70,228	50,151	0		1.00
	TOTALS		70,228	50,151			
	F - MED SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	95,221	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	95,221			
	G - COST OF DRUGS						
1.00	PHARMACY	15.00	0	448,011	0		1.00
	TOTALS		0	448,011			
	I - AMORT EXP						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	336,866	9		1.00
	TOTALS		0	336,866			
	J - OTHER RADIOLOGY COSTS						
1.00	ULTRASOUND	54.01	69,107	23,709	0		1.00
2.00	RADIOISOTOPE	56.00	0	102,159	0		2.00
3.00	CT SCAN	57.00	0	74,162	0		3.00
4.00	MRI	58.00	78,839	335,167	0		4.00
	TOTALS		147,946	535,197			
	K - RECOVERY ROOM						
1.00	RECOVERY ROOM	51.00	16,994	5,780	0		1.00
	TOTALS		16,994	5,780			
	M - RHC SALARY TO ADMIN						
1.00	RURAL HEALTH CLINIC	88.00	34,750	0	0		1.00
	TOTALS		34,750	0			
	N - INFECTION CONTROL						
1.00	ADMINISTRATIVE & GENERAL	5.00	27,874	6,746	0		1.00
	TOTALS		27,874	6,746			
500.00	Grand Total: Decreases		297,792	3,471,557			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2017 11:51 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	124,306	0	0	0	0	2.00
3.00	Buildings and Fixtures	5,634,980	0	0	0	0	3.00
4.00	Building Improvements	10,291,546	61,856	0	61,856	3,316	4.00
5.00	Fixed Equipment	2,306,072	6,032	0	6,032	1,105	5.00
6.00	Movable Equipment	10,402,913	238,270	0	238,270	200,797	6.00
7.00	HIT designated Assets	3,248,804	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,008,621	306,158	0	306,158	205,218	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	32,008,621	306,158	0	306,158	205,218	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	124,306	0	2.00
3.00	Buildings and Fixtures	5,634,980	0	3.00
4.00	Building Improvements	10,350,086	0	4.00
5.00	Fixed Equipment	2,310,999	0	5.00
6.00	Movable Equipment	10,440,386	0	6.00
7.00	HIT designated Assets	3,248,804	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,109,561	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	32,109,561	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2017 11:51 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	170,609	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,434,949	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,605,558	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	170,609		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,434,949		2.00
3.00	Total (sum of lines 1-2)	0	1,605,558		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/30/2017 11:51 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	16,109,372	0	16,109,372	0.501700	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	16,000,191	0	16,000,191	0.498300	0	2.00
3.00	Total (sum of lines 1-2)	32,109,563	0	32,109,563	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	696,632	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	901,339	316,157	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,597,971	316,157	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	22,584	60,060	0	779,276	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,289	0	0	1,219,785	2.00
3.00	Total (sum of lines 1-2)	0	24,873	60,060	0	1,999,061	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/30/2017 11:51 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		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	-3,717	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-394	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,199,127			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	1,275,727			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-24,779	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	-345	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	A	486,973	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-885,832	CAP REL COSTS-MVBLE EQUIP	2.00	9	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
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-1,723	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01			0		0.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/30/2017 11:51 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	FITNESS REV	B	-7,320	ADMINISTRATIVE & GENERAL	5.00	0	33.02
34.00			0		0.00	0	34.00
34.01			0		0.00	0	34.01
35.00	PATIENT PHONES BENEFIT COST	A	-508	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
36.00	PATIENT PHONES DEPRECIATION COST	A	-878	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
37.00	CABLE TV EXPENSE	A	-3,763	OPERATION OF PLANT	7.00	0	37.00
38.00	MARKETING EXPENSE - EXCLUDING MARKET	A	-104,936	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	PHYSICIAN RECRUITING	A	-14,198	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-19,895	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	CHARITABLE CONTRIBUTIONS	A	-3,748	ADMINISTRATIVE & GENERAL	5.00	0	41.00
41.01	SPECIAL EVENTS	A	-2,300	ADMINISTRATIVE & GENERAL	5.00	0	41.01
42.00	IL PROVIDER TAX	A	-482,856	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	LEGAL FEES	A	-1,752	ADMINISTRATIVE & GENERAL	5.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-995,371				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2017 11:51 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL RELATED COSTS(INT &	39,050	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL RELATED (MOVEABLE)	16,628	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	ALLOCATED COSTS	729,530	508,267	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	1,050,980	52,194	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,836,188	560,461	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B		0.00	COMMUNITY HEALT	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2017 11:51 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	39,050	9		1.00
2.00	16,628	9		2.00
3.00	221,263	9		3.00
4.00	998,786	9		4.00
5.00	1,275,727			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HOSPITAL MANAGE		6.00
7.00	COLLECTIONS		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2017 11:51 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	634,077	634,077	0	0	0	1.00
2.00	91.00	EMERGENCY	1,017,600	565,050	452,550	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	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			1,651,677	1,199,127	452,550		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	634,077		1.00
2.00	91.00	EMERGENCY	0	0	0	565,050		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,199,127		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/30/2017 11:51 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	779,276	779,276				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,219,785		1,219,785			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,687,661	6,170	9,658	1,703,489		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,597,540	58,171	91,053	280,341	5,027,105	5.00
7.00	00700	OPERATION OF PLANT	944,330	222,503	348,280	55,926	1,571,039	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,664	13,321	20,850	6,750	75,585	8.00
9.00	00900	HOUSEKEEPING	297,932	10,180	15,935	47,559	371,606	9.00
10.00	01000	DIETARY	422,212	25,154	39,373	46,649	533,388	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	854,306	18,755	29,356	173,188	1,075,605	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	127,060	15,535	24,317	20,630	187,542	14.00
15.00	01500	PHARMACY	378,080	9,737	15,242	66,059	469,118	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	179,233	9,049	14,164	20,949	223,395	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	848,112	55,948	87,574	159,021	1,150,655	30.00
46.00	04600	OTHER LONG TERM CARE	746,893	46,994	73,558	136,223	1,003,668	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	383,889	31,015	48,548	56,305	519,757	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	276,418	0	0	0	276,418	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	972,222	49,936	78,164	98,141	1,198,463	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	698,116	13,819	21,630	77,205	810,770	60.00
65.00	06500	RESPIRATORY THERAPY	52,514	4,896	7,664	10,033	75,107	65.00
66.00	06600	PHYSICAL THERAPY	559,134	34,045	53,290	104,895	751,364	66.00
67.00	06700	OCCUPATIONAL THERAPY	149,353	9,065	14,189	30,067	202,674	67.00
68.00	06800	SPEECH PATHOLOGY	90,863	1,392	2,179	18,490	112,924	68.00
69.00	06900	ELECTROCARDIOLOGY	81,005	6,004	9,398	14,474	110,881	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	118,093	0	0	0	118,093	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,003	0	0	0	1,003	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	448,011	0	0	0	448,011	73.00
76.00	03020	SLEEP LAB	95,650	0	0	0	95,650	76.00
76.03	03950	WOUND CARE	9,992	7,617	11,923	1,695	31,227	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	535,602	21,832	34,173	75,262	666,869	88.00
91.00	09100	EMERGENCY	1,488,603	37,256	58,317	188,252	1,772,428	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,077,552	708,394	1,108,835	1,688,114	18,880,345	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,718	5,819	0	9,537	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	55,373	49,651	77,718	0	182,742	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	120,379	3,093	4,841	15,375	143,688	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	2,862	3,599	5,634	0	12,095	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	10,821	16,938	0	27,759	194.04
194.05	07955	LEASED TO RURAL HEALTH ASSOCIATES	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	19,256,166	779,276	1,219,785	1,703,489	19,256,166	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/30/2017 11:51 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,027,105					5.00
7.00	00700	OPERATION OF PLANT	555,045	2,126,084				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,704	56,306	158,595			8.00
9.00	00900	HOUSEKEEPING	131,288	43,032	4,822	550,748		9.00
10.00	01000	DIETARY	188,445	106,326	666	28,893	857,718	10.00
11.00	01100	CAFETERIA	0	0	0	0	348,014	11.00
13.00	01300	NURSING ADMINISTRATION	380,009	79,276	0	21,543	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,258	65,668	0	17,845	0	14.00
15.00	01500	PHARMACY	165,738	41,160	0	11,185	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	78,925	38,251	0	10,394	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	406,524	236,491	32,446	64,264	199,700	30.00
46.00	04600	OTHER LONG TERM CARE	354,594	198,642	79,856	53,979	278,681	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	183,629	131,102	5,813	35,626	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	97,658	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	423,415	211,080	6,332	57,359	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	286,443	58,412	0	15,873	0	60.00
65.00	06500	RESPIRATORY THERAPY	26,535	20,697	0	5,624	0	65.00
66.00	06600	PHYSICAL THERAPY	265,455	143,908	9,339	39,106	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	71,604	38,317	0	10,412	0	67.00
68.00	06800	SPEECH PATHOLOGY	39,896	5,885	0	1,599	0	68.00
69.00	06900	ELECTROCARDIOLOGY	39,174	25,378	0	6,896	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	41,722	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	354	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	158,281	0	0	0	0	73.00
76.00	03020	SLEEP LAB	33,793	0	0	0	0	76.00
76.03	03950	WOUND CARE	11,032	32,199	0	8,750	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	235,603	92,283	1,309	25,077	0	88.00
91.00	09100	EMERGENCY	626,205	157,483	18,012	42,794	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,894,329	1,781,896	158,595	457,219	826,395	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,369	15,715	0	4,270	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	64,562	209,877	0	57,032	31,323	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	50,765	13,073	0	3,553	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	4,273	15,213	0	4,134	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	9,807	45,740	0	12,429	0	194.04
194.05	07955	LEASED TO RURAL HEALTH ASSOCIATES	0	44,570	0	12,111	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,027,105	2,126,084	158,595	550,748	857,718	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/30/2017 11:51 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	348,014					11.00
13.00	01300	NURSING ADMINISTRATION	34,962	1,591,395				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,297	0	345,610			14.00
15.00	01500	PHARMACY	10,140	0	2,767	700,108		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,150	0	1,949	0	362,064	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,268	591,157	32,557	0	20,626	30.00
46.00	04600	OTHER LONG TERM CARE	58,930	0	9,462	0	3,515	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,247	209,312	40,939	0	16,714	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	5,795	0	4,124	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,782	0	16,828	0	133,700	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	26,802	0	105,265	0	53,195	60.00
65.00	06500	RESPIRATORY THERAPY	2,936	37,297	2,199	0	1,085	65.00
66.00	06600	PHYSICAL THERAPY	24,856	0	7,267	0	14,986	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,897	0	373	0	3,990	67.00
68.00	06800	SPEECH PATHOLOGY	3,346	0	148	0	611	68.00
69.00	06900	ELECTROCARDIOLOGY	3,653	53,808	763	0	7,011	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	65,498	0	5,746	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	726	0	421	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	700,108	37,753	73.00
76.00	03020	SLEEP LAB	0	0	3,895	0	2,128	76.00
76.03	03950	WOUND CARE	990	0	1,194	0	787	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	16,593	0	7,195	0	4,591	88.00
91.00	09100	EMERGENCY	45,751	699,821	40,398	0	51,081	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	344,600	1,591,395	345,218	700,108	362,064	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	3,414	0	330	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	62	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	LEASED TO RURAL HEALTH ASSOCIATES	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	348,014	1,591,395	345,610	700,108	362,064	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/30/2017 11:51 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
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
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,783,688	0	2,783,688		30.00
46.00	04600	OTHER LONG TERM CARE	2,041,327	0	2,041,327		46.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,156,139	0	1,156,139		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	383,995	0	383,995		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,075,959	0	2,075,959		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	1,356,760	0	1,356,760		60.00
65.00	06500	RESPIRATORY THERAPY	171,480	0	171,480		65.00
66.00	06600	PHYSICAL THERAPY	1,256,281	0	1,256,281		66.00
67.00	06700	OCCUPATIONAL THERAPY	334,267	0	334,267		67.00
68.00	06800	SPEECH PATHOLOGY	164,409	0	164,409		68.00
69.00	06900	ELECTROCARDIOLOGY	247,564	0	247,564		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	231,059	0	231,059		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,504	0	2,504		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,344,153	0	1,344,153		73.00
76.00	03020	SLEEP LAB	135,466	0	135,466		76.00
76.03	03950	WOUND CARE	86,179	0	86,179		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,049,520	0	1,049,520		88.00
91.00	09100	EMERGENCY	3,453,973	0	3,453,973		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,274,723	0	18,274,723		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	32,891	0	32,891		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	545,536	0	545,536		192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	214,823	0	214,823		194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	35,777	0	35,777		194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0		194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	95,735	0	95,735		194.04
194.05	07955	LEASED TO RURAL HEALTH ASSOCIATES	56,681	0	56,681		194.05
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	19,256,166	0	19,256,166		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/30/2017 11:51 am

		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	6,170	9,658	15,828	15,828	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	58,171	91,053	149,224	2,605	5.00
7.00	00700	OPERATION OF PLANT	0	222,503	348,280	570,783	520	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,321	20,850	34,171	63	8.00
9.00	00900	HOUSEKEEPING	0	10,180	15,935	26,115	442	9.00
10.00	01000	DIETARY	0	25,154	39,373	64,527	433	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	18,755	29,356	48,111	1,609	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	15,535	24,317	39,852	192	14.00
15.00	01500	PHARMACY	0	9,737	15,242	24,979	614	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,049	14,164	23,213	195	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	55,948	87,574	143,522	1,477	30.00
46.00	04600	OTHER LONG TERM CARE	0	46,994	73,558	120,552	1,266	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	31,015	48,548	79,563	523	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,936	78,164	128,100	912	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	13,819	21,630	35,449	717	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,896	7,664	12,560	93	65.00
66.00	06600	PHYSICAL THERAPY	0	34,045	53,290	87,335	975	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,065	14,189	23,254	279	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,392	2,179	3,571	172	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,004	9,398	15,402	134	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.03	03950	WOUND CARE	0	7,617	11,923	19,540	16	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	21,832	34,173	56,005	699	88.00
91.00	09100	EMERGENCY	0	37,256	58,317	95,573	1,749	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	708,394	1,108,835	1,817,229	15,685	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,718	5,819	9,537	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	49,651	77,718	127,369	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	3,093	4,841	7,934	143	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	3,599	5,634	9,233	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	10,821	16,938	27,759	0	194.04
194.05	07955	LEASED TO RURAL HEALTH ASSOCIATES	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	779,276	1,219,785	1,999,061	15,828	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/30/2017 11:51 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	151,829					5.00
7.00	00700	OPERATION OF PLANT	16,763	588,066				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	806	15,574	50,614			8.00
9.00	00900	HOUSEKEEPING	3,965	11,902	1,539	43,963		9.00
10.00	01000	DIETARY	5,691	29,409	213	2,306	102,579	10.00
11.00	01100	CAFETERIA	0	0	0	0	41,621	11.00
13.00	01300	NURSING ADMINISTRATION	11,477	21,928	0	1,720	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,001	18,163	0	1,424	0	14.00
15.00	01500	PHARMACY	5,005	11,385	0	893	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,384	10,580	0	830	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,277	65,412	10,355	5,128	23,883	30.00
46.00	04600	OTHER LONG TERM CARE	10,709	54,944	25,485	4,309	33,329	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,546	36,262	1,855	2,844	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	2,949	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,788	58,384	2,021	4,579	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	8,651	16,157	0	1,267	0	60.00
65.00	06500	RESPIRATORY THERAPY	801	5,725	0	449	0	65.00
66.00	06600	PHYSICAL THERAPY	8,017	39,804	2,980	3,122	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,163	10,598	0	831	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,205	1,628	0	128	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,183	7,019	0	550	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,260	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,780	0	0	0	0	73.00
76.00	03020	SLEEP LAB	1,021	0	0	0	0	76.00
76.03	03950	WOUND CARE	333	8,906	0	698	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,115	25,525	418	2,002	0	88.00
91.00	09100	EMERGENCY	18,918	43,559	5,748	3,416	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	147,819	492,864	50,614	36,496	98,833	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	102	4,347	0	341	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,950	58,051	0	4,553	3,746	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	1,533	3,616	0	284	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	129	4,208	0	330	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	296	12,652	0	992	0	194.04
194.05	07955	LEASED TO RURAL HEALTH ASSOCIATES	0	12,328	0	967	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	151,829	588,066	50,614	43,963	102,579	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/30/2017 11:51 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	41,621					11.00
13.00	01300	NURSING ADMINISTRATION	4,181	89,026				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	992	0	62,624			14.00
15.00	01500	PHARMACY	1,213	0	501	44,590		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,094	0	353	0	38,649	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,892	33,071	5,899	0	2,204	30.00
46.00	04600	OTHER LONG TERM CARE	7,050	0	1,715	0	376	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,584	11,709	7,418	0	1,786	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	1,050	0	441	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,442	0	3,049	0	14,248	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	3,205	0	19,075	0	5,684	60.00
65.00	06500	RESPIRATORY THERAPY	351	2,087	398	0	116	65.00
66.00	06600	PHYSICAL THERAPY	2,973	0	1,317	0	1,601	66.00
67.00	06700	OCCUPATIONAL THERAPY	825	0	68	0	426	67.00
68.00	06800	SPEECH PATHOLOGY	400	0	27	0	65	68.00
69.00	06900	ELECTROCARDIOLOGY	437	3,010	138	0	749	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	11,868	0	614	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	131	0	45	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	44,590	4,034	73.00
76.00	03020	SLEEP LAB	0	0	706	0	227	76.00
76.03	03950	WOUND CARE	118	0	216	0	84	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,984	0	1,304	0	491	88.00
91.00	09100	EMERGENCY	5,472	39,149	7,320	0	5,458	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,213	89,026	62,553	44,590	38,649	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	408	0	60	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	11	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	LEASED TO RURAL HEALTH ASSOCIATES	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	41,621	89,026	62,624	44,590	38,649	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/30/2017 11:51 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
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
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	309,120	0	309,120		30.00
46.00	04600	OTHER LONG TERM CARE	259,735	0	259,735		46.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	149,090	0	149,090		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	4,440	0	4,440		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	227,523	0	227,523		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	90,205	0	90,205		60.00
65.00	06500	RESPIRATORY THERAPY	22,580	0	22,580		65.00
66.00	06600	PHYSICAL THERAPY	148,124	0	148,124		66.00
67.00	06700	OCCUPATIONAL THERAPY	38,444	0	38,444		67.00
68.00	06800	SPEECH PATHOLOGY	7,196	0	7,196		68.00
69.00	06900	ELECTROCARDIOLOGY	28,622	0	28,622		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,742	0	13,742		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	187	0	187		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	53,404	0	53,404		73.00
76.00	03020	SLEEP LAB	1,954	0	1,954		76.00
76.03	03950	WOUND CARE	29,911	0	29,911		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	95,543	0	95,543		88.00
91.00	09100	EMERGENCY	226,362	0	226,362		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,706,182	0	1,706,182		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,327	0	14,327		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	195,669	0	195,669		192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	13,978	0	13,978		194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	13,911	0	13,911		194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0		194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	41,699	0	41,699		194.04
194.05	07955	LEASED TO RURAL HEALTH ASSOCIATES	13,295	0	13,295		194.05
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	1,999,061	0	1,999,061		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 11:51 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	98,517					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		98,517				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	780	780	7,781,130			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,354	7,354	1,280,543	-5,027,105	14,229,061	5.00
7.00	00700	OPERATION OF PLANT	28,129	28,129	255,458	0	1,571,039	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,684	1,684	30,831	0	75,585	8.00
9.00	00900	HOUSEKEEPING	1,287	1,287	217,236	0	371,606	9.00
10.00	01000	DIETARY	3,180	3,180	213,079	0	533,388	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,371	2,371	791,082	0	1,075,605	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,964	1,964	94,234	0	187,542	14.00
15.00	01500	PHARMACY	1,231	1,231	301,739	0	469,118	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,144	1,144	95,692	0	223,395	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,073	7,073	726,370	0	1,150,655	30.00
46.00	04600	OTHER LONG TERM CARE	5,941	5,941	622,235	0	1,003,668	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,921	3,921	257,187	0	519,757	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	276,418	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,313	6,313	448,285	0	1,198,463	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,747	1,747	352,652	0	810,770	60.00
65.00	06500	RESPIRATORY THERAPY	619	619	45,828	0	75,107	65.00
66.00	06600	PHYSICAL THERAPY	4,304	4,304	479,133	0	751,364	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,146	1,146	137,337	0	202,674	67.00
68.00	06800	SPEECH PATHOLOGY	176	176	84,457	0	112,924	68.00
69.00	06900	ELECTROCARDIOLOGY	759	759	66,115	0	110,881	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	118,093	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,003	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	448,011	73.00
76.00	03020	SLEEP LAB	0	0	0	0	95,650	76.00
76.03	03950	WOUND CARE	963	963	7,742	0	31,227	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,760	2,760	343,778	0	666,869	88.00
91.00	09100	EMERGENCY	4,710	4,710	859,889	0	1,772,428	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	89,556	89,556	7,710,902	-5,027,105	13,853,240	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	470	470	0	0	9,537	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,277	6,277	0	0	182,742	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	391	391	70,228	0	143,688	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	455	455	0	0	12,095	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	1,368	1,368	0	0	27,759	194.04
194.05	07955	LEASED TO RURAL HEALTH ASSOCIATES	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	779,276	1,219,785	1,703,489		5,027,105	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.910066	12.381467	0.218926		0.353298	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			15,828		151,829	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002034		0.010670	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 11:51 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LBS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	63,587					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,684	61,442				8.00
9.00	00900	HOUSEKEEPING	1,287	1,868	60,616			9.00
10.00	01000	DIETARY	3,180	258	3,180	52,713		10.00
11.00	01100	CAFETERIA	0	0	0	21,388	10,193	11.00
13.00	01300	NURSING ADMINISTRATION	2,371	0	2,371	0	1,024	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,964	0	1,964	0	243	14.00
15.00	01500	PHARMACY	1,231	0	1,231	0	297	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,144	0	1,144	0	268	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,073	12,570	7,073	12,273	1,443	30.00
46.00	04600	OTHER LONG TERM CARE	5,941	30,938	5,941	17,127	1,726	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,921	2,252	3,921	0	388	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,313	2,453	6,313	0	843	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,747	0	1,747	0	785	60.00
65.00	06500	RESPIRATORY THERAPY	619	0	619	0	86	65.00
66.00	06600	PHYSICAL THERAPY	4,304	3,618	4,304	0	728	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,146	0	1,146	0	202	67.00
68.00	06800	SPEECH PATHOLOGY	176	0	176	0	98	68.00
69.00	06900	ELECTROCARDIOLOGY	759	0	759	0	107	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.03	03950	WOUND CARE	963	0	963	0	29	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,760	507	2,760	0	486	88.00
91.00	09100	EMERGENCY	4,710	6,978	4,710	0	1,340	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	53,293	61,442	50,322	50,788	10,093	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	470	0	470	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,277	0	6,277	1,925	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	391	0	391	0	100	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	455	0	455	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	1,368	0	1,368	0	0	194.04
194.05	07955	LEASED TO RURAL HEALTH ASSOCIATES	1,333	0	1,333	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,126,084	158,595	550,748	857,718	348,014	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.435828	2.581215	9.085852	16.271470	34.142451	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	588,066	50,614	43,963	102,579	41,621	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	9.248211	0.823769	0.725271	1.945991	4.083292	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 11:51 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	1,955,389					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	477,799				14.00
15.00	01500	PHARMACY	0	3,826	448,011			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,695	0	81,794,469		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	726,370	45,010	0	4,659,232		30.00
46.00	04600	OTHER LONG TERM CARE	0	13,081	0	793,958		46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	257,187	56,598	0	3,775,532		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	8,011	0	931,523		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,264	0	30,210,391		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	145,526	0	12,015,927		60.00
65.00	06500	RESPIRATORY THERAPY	45,828	3,040	0	245,002		65.00
66.00	06600	PHYSICAL THERAPY	0	10,046	0	3,385,167		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	516	0	901,180		67.00
68.00	06800	SPEECH PATHOLOGY	0	204	0	138,081		68.00
69.00	06900	ELECTROCARDIOLOGY	66,115	1,055	0	1,583,753		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	90,549	0	1,297,961		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,003	0	95,089		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	448,011	8,527,823		73.00
76.00	03020	SLEEP LAB	0	5,385	0	480,590		76.00
76.03	03950	WOUND CARE	0	1,651	0	177,674		76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	9,947	0	1,037,129		88.00
91.00	09100	EMERGENCY	859,889	55,850	0	11,538,457		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,955,389	477,257	448,011	81,794,469		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	456	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	86	0	0		194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0		194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0		194.04
194.05	07955	LEASED TO RURAL HEALTH ASSOCIATES	0	0	0	0		194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,591,395	345,610	700,108	362,064		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.813851	0.723338	1.562703	0.004427		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	89,026	62,624	44,590	38,649		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.045529	0.131068	0.099529	0.000473		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 11:51 am

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	2,783,688		2,783,688	0	0	30.00
46.00	04600	OTHER LONG TERM CARE	2,041,327		2,041,327	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,156,139		1,156,139	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	383,995		383,995	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,075,959		2,075,959	0	0	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	1,356,760		1,356,760	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	171,480	0	171,480	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,256,281	0	1,256,281	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	334,267	0	334,267	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	164,409	0	164,409	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	247,564		247,564	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	231,059		231,059	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,504		2,504	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,344,153		1,344,153	0	0	73.00
76.00	03020	SLEEP LAB	135,466		135,466	0	0	76.00
76.03	03950	WOUND CARE	86,179		86,179	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,049,520		1,049,520	0	0	88.00
91.00	09100	EMERGENCY	3,453,973		3,453,973	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	277,224		277,224		0	92.00
200.00		Subtotal (see instructions)	18,551,947	0	18,551,947	0	0	200.00
201.00		Less Observation Beds	277,224		277,224		0	201.00
202.00		Total (see instructions)	18,274,723	0	18,274,723	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 11:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,878,180		3,878,180			30.00
46.00	04600	OTHER LONG TERM CARE	793,958		793,958			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,561	3,722,971	3,775,532	0.306219	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	14,176	917,347	931,523	0.412223	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,080,225	29,130,166	30,210,391	0.068717	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,603,051	10,412,876	12,015,927	0.112913	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	171,511	73,491	245,002	0.699913	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	768,241	2,616,926	3,385,167	0.371113	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	624,103	277,077	901,180	0.370921	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	27,768	110,313	138,081	1.190671	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	44,956	1,538,797	1,583,753	0.156315	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	841,768	456,193	1,297,961	0.178017	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	114	94,975	95,089	0.026333	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,563,506	4,964,317	8,527,823	0.157620	0.000000	73.00
76.00	03020	SLEEP LAB	0	480,590	480,590	0.281874	0.000000	76.00
76.03	03950	WOUND CARE	0	177,674	177,674	0.485040	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,037,129	1,037,129			88.00
91.00	09100	EMERGENCY	16,916	11,521,541	11,538,457	0.299344	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,169	776,883	781,052	0.354937	0.000000	92.00
200.00		Subtotal (see instructions)	13,485,203	68,309,266	81,794,469			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,485,203	68,309,266	81,794,469			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 11:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
46.00	04600	OTHER LONG TERM CARE		46.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
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
76.00	03020	SLEEP LAB	0.000000	76.00
76.03	03950	WOUND CARE	0.000000	76.03
		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
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: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 11:51 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,783,688		2,783,688	0	2,783,688	30.00
46.00	04600	OTHER LONG TERM CARE	2,041,327		2,041,327	0	2,041,327	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,156,139		1,156,139	0	1,156,139	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	383,995		383,995	0	383,995	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,075,959		2,075,959	0	2,075,959	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	1,356,760		1,356,760	0	1,356,760	60.00
65.00	06500	RESPIRATORY THERAPY	171,480	0	171,480	0	171,480	65.00
66.00	06600	PHYSICAL THERAPY	1,256,281	0	1,256,281	0	1,256,281	66.00
67.00	06700	OCCUPATIONAL THERAPY	334,267	0	334,267	0	334,267	67.00
68.00	06800	SPEECH PATHOLOGY	164,409	0	164,409	0	164,409	68.00
69.00	06900	ELECTROCARDIOLOGY	247,564		247,564	0	247,564	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	231,059		231,059	0	231,059	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,504		2,504	0	2,504	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,344,153		1,344,153	0	1,344,153	73.00
76.00	03020	SLEEP LAB	135,466		135,466	0	135,466	76.00
76.03	03950	WOUND CARE	86,179		86,179	0	86,179	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,049,520		1,049,520	0	1,049,520	88.00
91.00	09100	EMERGENCY	3,453,973		3,453,973	0	3,453,973	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	277,224		277,224		277,224	92.00
200.00		Subtotal (see instructions)	18,551,947	0	18,551,947	0	18,551,947	200.00
201.00		Less Observation Beds	277,224		277,224		277,224	201.00
202.00		Total (see instructions)	18,274,723	0	18,274,723	0	18,274,723	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 11:51 am

Title XIX | Hospital | PPS

		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	3,878,180		3,878,180			30.00
46.00	04600	OTHER LONG TERM CARE	793,958		793,958			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,561	3,722,971	3,775,532	0.306219	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	14,176	917,347	931,523	0.412223	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,080,225	29,130,166	30,210,391	0.068717	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,603,051	10,412,876	12,015,927	0.112913	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	171,511	73,491	245,002	0.699913	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	768,241	2,616,926	3,385,167	0.371113	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	624,103	277,077	901,180	0.370921	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	27,768	110,313	138,081	1.190671	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	44,956	1,538,797	1,583,753	0.156315	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	841,768	456,193	1,297,961	0.178017	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	114	94,975	95,089	0.026333	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,563,506	4,964,317	8,527,823	0.157620	0.000000	73.00
76.00	03020	SLEEP LAB	0	480,590	480,590	0.281874	0.000000	76.00
76.03	03950	WOUND CARE	0	177,674	177,674	0.485040	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,037,129	1,037,129	1.011947	0.000000	88.00
91.00	09100	EMERGENCY	16,916	11,521,541	11,538,457	0.299344	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,169	776,883	781,052	0.354937	0.000000	92.00
200.00		Subtotal (see instructions)	13,485,203	68,309,266	81,794,469			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,485,203	68,309,266	81,794,469			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 11:51 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
46.00	04600	OTHER LONG TERM CARE		46.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.306219	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.412223	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.068717	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.112913	60.00
65.00	06500	RESPIRATORY THERAPY	0.699913	65.00
66.00	06600	PHYSICAL THERAPY	0.371113	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.370921	67.00
68.00	06800	SPEECH PATHOLOGY	1.190671	68.00
69.00	06900	ELECTROCARDIOLOGY	0.156315	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.178017	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.026333	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.157620	73.00
76.00	03020	SLEEP LAB	0.281874	76.00
76.03	03950	WOUND CARE	0.485040	76.03
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	1.011947	88.00
91.00	09100	EMERGENCY	0.299344	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.354937	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part II | Date/Time Prepared: 5/30/2017 11:51 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,156,139	149,090	1,007,049	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	383,995	4,440	379,555	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,075,959	227,523	1,848,436	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,356,760	90,205	1,266,555	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	171,480	22,580	148,900	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,256,281	148,124	1,108,157	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	334,267	38,444	295,823	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	164,409	7,196	157,213	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	247,564	28,622	218,942	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	231,059	13,742	217,317	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,504	187	2,317	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,344,153	53,404	1,290,749	0	0	73.00
76.00	03020	SLEEP LAB	135,466	1,954	133,512	0	0	76.00
76.03	03950	WOUND CARE	86,179	29,911	56,268	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,049,520	95,543	953,977	0	0	88.00
91.00	09100	EMERGENCY	3,453,973	226,362	3,227,611	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	277,224	30,785	246,439	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	13,726,932	1,168,112	12,558,820	0	0	200.00
201.00		Less Observation Beds	277,224	30,785	246,439	0	0	201.00
202.00		Total (line 200 minus line 201)	13,449,708	1,137,327	12,312,381	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part II Date/Time Prepared: 5/30/2017 11:51 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,156,139	3,775,532	0.306219		50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	383,995	931,523	0.412223		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,075,959	30,210,391	0.068717		54.00
54.01	05401	ULTRASOUND	0	0	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MRI	0	0	0.000000		58.00
60.00	06000	LABORATORY	1,356,760	12,015,927	0.112913		60.00
65.00	06500	RESPIRATORY THERAPY	171,480	245,002	0.699913		65.00
66.00	06600	PHYSICAL THERAPY	1,256,281	3,385,167	0.371113		66.00
67.00	06700	OCCUPATIONAL THERAPY	334,267	901,180	0.370921		67.00
68.00	06800	SPEECH PATHOLOGY	164,409	138,081	1.190671		68.00
69.00	06900	ELECTROCARDIOLOGY	247,564	1,583,753	0.156315		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	231,059	1,297,961	0.178017		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,504	95,089	0.026333		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,344,153	8,527,823	0.157620		73.00
76.00	03020	SLEEP LAB	135,466	480,590	0.281874		76.00
76.03	03950	WOUND CARE	86,179	177,674	0.485040		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,049,520	1,037,129	1.011947		88.00
91.00	09100	EMERGENCY	3,453,973	11,538,457	0.299344		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	277,224	781,052	0.354937		92.00
200.00		Subtotal (sum of lines 50 thru 199)	13,726,932	77,122,331			200.00
201.00		Less Observation Beds	277,224	0			201.00
202.00		Total (line 200 minus line 201)	13,449,708	77,122,331			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/30/2017 11:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	149,090	3,775,532	0.039488	21,441	847	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	4,440	931,523	0.004766	1,541	7	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	227,523	30,210,391	0.007531	624,549	4,703	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	90,205	12,015,927	0.007507	868,744	6,522	60.00
65.00	06500	RESPIRATORY THERAPY	22,580	245,002	0.092163	122,437	11,284	65.00
66.00	06600	PHYSICAL THERAPY	148,124	3,385,167	0.043757	53,540	2,343	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,444	901,180	0.042660	17,921	765	67.00
68.00	06800	SPEECH PATHOLOGY	7,196	138,081	0.052114	15,799	823	68.00
69.00	06900	ELECTROCARDIOLOGY	28,622	1,583,753	0.018072	25,558	462	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,742	1,297,961	0.010587	508,204	5,380	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	187	95,089	0.001967	38	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	53,404	8,527,823	0.006262	1,840,570	11,526	73.00
76.00	03020	SLEEP LAB	1,954	480,590	0.004066	0	0	76.00
76.03	03950	WOUND CARE	29,911	177,674	0.168348	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	95,543	1,037,129	0.092123	0	0	88.00
91.00	09100	EMERGENCY	226,362	11,538,457	0.019618	3,784	74	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	30,785	781,052	0.039415	2,780	110	92.00
200.00		Total (lines 50-199)	1,168,112	77,122,331		4,106,906	44,846	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/30/2017 11:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/30/2017 11:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,775,532	0.000000	0.000000	21,441	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	931,523	0.000000	0.000000	1,541	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,210,391	0.000000	0.000000	624,549	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	12,015,927	0.000000	0.000000	868,744	60.00
65.00	06500	RESPIRATORY THERAPY	0	245,002	0.000000	0.000000	122,437	65.00
66.00	06600	PHYSICAL THERAPY	0	3,385,167	0.000000	0.000000	53,540	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	901,180	0.000000	0.000000	17,921	67.00
68.00	06800	SPEECH PATHOLOGY	0	138,081	0.000000	0.000000	15,799	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,583,753	0.000000	0.000000	25,558	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,297,961	0.000000	0.000000	508,204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	95,089	0.000000	0.000000	38	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,527,823	0.000000	0.000000	1,840,570	73.00
76.00	03020	SLEEP LAB	0	480,590	0.000000	0.000000	0	76.00
76.03	03950	WOUND CARE	0	177,674	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,037,129	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	11,538,457	0.000000	0.000000	3,784	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	781,052	0.000000	0.000000	2,780	92.00
200.00		Total (lines 50-199)	0	77,122,331			4,106,906	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/30/2017 11:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
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
76.00	03020	SLEEP LAB	0	0	0		76.00
76.03	03950	WOUND CARE	0	0	0		76.03
		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
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/30/2017 11:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.306219	0	1,107,434	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.412223	0	75,424	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.068717	0	9,544,013	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.112913	0	3,723,780	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.699913	0	44,104	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.371113	0	892,288	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.370921	0	90,311	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.190671	0	34,059	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.156315	0	607,153	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.178017	0	177,811	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.026333	0	21,357	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.157620	0	1,510,539	0	0	73.00
76.00	03020	SLEEP LAB	0.281874	0	152,915	0	0	76.00
76.03	03950	WOUND CARE	0.485040	0	77,378	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.299344	0	3,678,284	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.354937	0	348,880	0	0	92.00
200.00		Subtotal (see instructions)		0	22,085,730	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	22,085,730	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/30/2017 11:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	339,117	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	31,092	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	655,836	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	420,463	0		60.00
65.00	06500	RESPIRATORY THERAPY	30,869	0		65.00
66.00	06600	PHYSICAL THERAPY	331,140	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	33,498	0		67.00
68.00	06800	SPEECH PATHOLOGY	40,553	0		68.00
69.00	06900	ELECTROCARDIOLOGY	94,907	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	31,653	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	562	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	238,091	0		73.00
76.00	03020	SLEEP LAB	43,103	0		76.00
76.03	03950	WOUND CARE	37,531	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	1,101,072	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	123,830	0		92.00
200.00		Subtotal (see instructions)	3,553,317	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,553,317	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1342 | Component CCN: 14-Z342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/30/2017 11:51 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.306219	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.412223	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.068717	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.112913	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.699913	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.371113	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.370921	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.190671	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.156315	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.178017	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.026333	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.157620	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0.281874	0	0	0	0	76.00
76.03	03950	WOUND CARE	0.485040	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.299344	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.354937	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1342 | Component CCN: 14-Z342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/30/2017 11:51 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
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
76.00	03020	SLEEP LAB	0	0		76.00
76.03	03950	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 5/30/2017 11:51 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	309,120	95,104	214,016	2,169	98.67	30.00
200.00	Total (lines 30-199)	309,120		214,016	2,169		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	209	20,622	30.00
200.00	Total (lines 30-199)	209	20,622	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/30/2017 11:51 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	149,090	3,775,532	0.039488	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	4,440	931,523	0.004766	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	227,523	30,210,391	0.007531	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	90,205	12,015,927	0.007507	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	22,580	245,002	0.092163	0	0	65.00
66.00	06600	PHYSICAL THERAPY	148,124	3,385,167	0.043757	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,444	901,180	0.042660	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,196	138,081	0.052114	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	28,622	1,583,753	0.018072	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,742	1,297,961	0.010587	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	187	95,089	0.001967	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	53,404	8,527,823	0.006262	0	0	73.00
76.00	03020	SLEEP LAB	1,954	480,590	0.004066	0	0	76.00
76.03	03950	WOUND CARE	29,911	177,674	0.168348	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	95,543	1,037,129	0.092123	0	0	88.00
91.00	09100	EMERGENCY	226,362	11,538,457	0.019618	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	30,785	781,052	0.039415	0	0	92.00
200.00		Total (lines 50-199)	1,168,112	77,122,331		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/30/2017 11:51 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,169	0.00	209	0		30.00
200.00		Total (lines 30-199)	2,169		209	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/30/2017 11:51 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/30/2017 11:51 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,775,532	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	931,523	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,210,391	0.000000	0.000000	0	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	12,015,927	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	245,002	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,385,167	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	901,180	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	138,081	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,583,753	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,297,961	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	95,089	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,527,823	0.000000	0.000000	0	73.00
76.00	03020	SLEEP LAB	0	480,590	0.000000	0.000000	0	76.00
76.03	03950	WOUND CARE	0	177,674	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,037,129	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	11,538,457	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	781,052	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	77,122,331			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/30/2017 11:51 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
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
76.00	03020	SLEEP LAB	0	0	0		76.00
76.03	03950	WOUND CARE	0	0	0		76.03
		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
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 11:51 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,390	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,169	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.	99	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,758	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	883	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	338	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,219	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)	883	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	18	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	212.56	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,783,688	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)	71,845	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	856,435	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,927,253	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	2,646,354	28.00
29.00	Private room charges (excluding swing-bed charges)	155,794	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	2,490,560	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.728267	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	1,573.68	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,416.70	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	156.98	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	114.32	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	11,318	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,915,935	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)	883.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,076,779	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	2,058	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,078,837	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 11:51 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	665,928	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,744,765	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)	779,980	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	779,980	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)	312	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	888.54	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	277,224	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 11:51 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	309,120	2,783,688	0.111047	277,224	30,785	90.00
91.00	Nursing School cost	0	2,783,688	0.000000	277,224	0	91.00
92.00	Allied health cost	0	2,783,688	0.000000	277,224	0	92.00
93.00	All other Medical Education	0	2,783,688	0.000000	277,224	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 11:51 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,390	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,169	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.	99	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,758	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	883	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	338	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	209	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	212.56	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,783,688	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)	71,845	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	856,435	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,927,253	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	2,646,354	28.00
29.00	Private room charges (excluding swing-bed charges)	155,794	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	2,490,560	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.728267	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	1,573.68	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,416.70	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	156.98	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	114.32	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	11,318	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,915,935	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)	888.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	185,705	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)	185,705	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 11:51 am

Title XIX | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	185,705	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)	20,622	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)	20,622	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	165,083	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	312	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	888.54	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	277,224	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 11:51 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	309,120	2,783,688	0.111047	277,224	30,785	90.00
91.00	Nursing School cost	0	2,783,688	0.000000	277,224	0	91.00
92.00	Allied health cost	0	2,783,688	0.000000	277,224	0	92.00
93.00	All other Medical Education	0	2,783,688	0.000000	277,224	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/30/2017 11:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,738,005		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.306219	21,441	6,566	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.412223	1,541	635	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.068717	624,549	42,917	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.112913	868,744	98,092	60.00
65.00	06500	RESPIRATORY THERAPY	0.699913	122,437	85,695	65.00
66.00	06600	PHYSICAL THERAPY	0.371113	53,540	19,869	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.370921	17,921	6,647	67.00
68.00	06800	SPEECH PATHOLOGY	1.190671	15,799	18,811	68.00
69.00	06900	ELECTROCARDIOLOGY	0.156315	25,558	3,995	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.178017	508,204	90,469	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.026333	38	1	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.157620	1,840,570	290,111	73.00
76.00	03020	SLEEP LAB	0.281874	0	0	76.00
76.03	03950	WOUND CARE	0.485040	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.299344	3,784	1,133	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.354937	2,780	987	92.00
200.00		Total (sum of lines 50-94 and 96-98)		4,106,906	665,928	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		4,106,906		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3

Component CCN: 14-Z342 | Date/Time Prepared: 5/30/2017 11:51 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.306219	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.412223	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.068717	76,953	5,288	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.112913	223,036	25,184	60.00
65.00	06500	RESPIRATORY THERAPY	0.699913	10,839	7,586	65.00
66.00	06600	PHYSICAL THERAPY	0.371113	482,924	179,219	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.370921	434,483	161,159	67.00
68.00	06800	SPEECH PATHOLOGY	1.190671	4,332	5,158	68.00
69.00	06900	ELECTROCARDIOLOGY	0.156315	2,200	344	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.178017	105,274	18,741	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.026333	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.157620	573,876	90,454	73.00
76.00	03020	SLEEP LAB	0.281874	0	0	76.00
76.03	03950	WOUND CARE	0.485040	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.299344	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.354937	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,913,917	493,133	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,913,917		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1342	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/30/2017 11:51 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,553,317	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)	3,553,317	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)	3,588,850	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)	56,770	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,658,229	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)	-126,149	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)	-126,149	30.00
31.00	Primary payer payments	111	31.00
32.00	Subtotal (line 30 minus line 31)	-126,260	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)	838,885	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	545,275	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	788,262	36.00
37.00	Subtotal (see instructions)	419,015	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)	419,015	40.00
40.01	Sequestration adjustment (see instructions)	8,380	40.01
41.00	Interim payments	894,849	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-484,214	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 5/30/2017 11:51 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,385,306		755,549	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/04/2016	43,000	08/04/2016	139,300	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		43,000		139,300	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,428,306		894,849	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		46,273		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		484,214	6.02
7.00	Total Medicare program liability (see instructions)		1,474,579		410,635	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1342 | Component CCN: 14-Z342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2017 11:51 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,144,086		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,144,086		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		99,982		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,244,068		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1342	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/30/2017 11:51 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	534	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,219	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	201	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,857	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	81,794,469	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	138,388	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1342 | Component CCN: 14-Z342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-2 | Date/Time Prepared: 5/30/2017 11:51 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	787,780	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)	498,064	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	883	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,285,844	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,285,844	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,285,844	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	16,387	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,269,457	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,269,457	0	19.00
19.01	Sequestration adjustment (see instructions)	25,389	0	19.01
20.00	Interim payments	1,144,086	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)	99,982	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1342	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part V Date/Time Prepared: 5/30/2017 11:51 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,744,765	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,744,765	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,762,213	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,762,213	19.00
20.00	Deductibles (exclude professional component)	298,760	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,463,453	22.00
23.00	Coinsurance	8,050	23.00
24.00	Subtotal (line 22 minus line 23)	1,455,403	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	75,798	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	49,269	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	63,393	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,504,672	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	1,504,672	30.00
30.01	Sequestration adjustment (see instructions)	30,093	30.01
31.00	Interim payments	1,428,306	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)	46,273	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: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/30/2017 11:51 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-342,708	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	8,296,606	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-661,892	0	0	0	6.00
7.00	Inventory	421,718	0	0	0	7.00
8.00	Prepaid expenses	223,564	0	0	0	8.00
9.00	Other current assets	3,580	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)	7,940,868	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	76,833	0	0	0	13.00
14.00	Accumulated depreciation	-23,023	0	0	0	14.00
15.00	Buildings	3,304,483	0	0	0	15.00
16.00	Accumulated depreciation	-1,636,168	0	0	0	16.00
17.00	Leasehold improvements	9,152,639	0	0	0	17.00
18.00	Accumulated depreciation	-3,052,912	0	0	0	18.00
19.00	Fixed equipment	1,420,229	0	0	0	19.00
20.00	Accumulated depreciation	-463,717	0	0	0	20.00
21.00	Automobiles and trucks	57,058	0	0	0	21.00
22.00	Accumulated depreciation	-57,058	0	0	0	22.00
23.00	Major movable equipment	4,376,996	0	0	0	23.00
24.00	Accumulated depreciation	-3,458,586	0	0	0	24.00
25.00	Minor equipment depreciable	3,360,787	0	0	0	25.00
26.00	Accumulated depreciation	-2,844,013	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)	10,213,548	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,929,183	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,929,183	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	20,083,599	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	696,450	0	0	0	37.00
38.00	Salaries, wages, and fees payable	792,443	0	0	0	38.00
39.00	Payroll taxes payable	73,463	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-1,381,628	0	0	0	43.00
44.00	Other current liabilities	88,349	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	269,077	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	269,077	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	19,814,522				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	19,814,522	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	20,083,599	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/30/2017 11:51 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		15,902,898		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,911,628				2.00
3.00	Total (sum of line 1 and line 2)		19,814,526		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		19,814,526		0		11.00
12.00	ROUNDING	4		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)		4		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		19,814,522		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1342 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/30/2017 11:51 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,646,354		2,646,354	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,231,826		1,231,826	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	793,958		793,958	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,672,138		4,672,138	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,672,138		4,672,138	17.00
18.00	Ancillary services	8,791,980	54,973,713	63,765,693	18.00
19.00	Outpatient services	21,085	12,298,424	12,319,509	19.00
20.00	RURAL HEALTH CLINIC	0	1,037,129	1,037,129	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	13,485,203	68,309,266	81,794,469	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,251,537		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)		20,251,537		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1342	Period: From 01/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Prepared: 5/30/2017 11:51 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	81,794,469	1.00
2.00	Less contractual allowances and discounts on patients' accounts	57,679,766	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,114,703	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,251,537	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,863,166	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER MISC REVENUE	48,462	24.00
25.00	Total other income (sum of lines 6-24)	48,462	25.00
26.00	Total (line 5 plus line 25)	3,911,628	26.00
27.00		0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,911,628	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1342 | Component CCN: 14-3975 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-1 | Date/Time Prepared: 5/30/2017 11:51 am

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	39,561	0	39,561	0	39,561	1.00
2.00	Physician Assistant	199,300	0	199,300	0	199,300	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	104,600	0	104,600	0	104,600	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	343,461	0	343,461	0	343,461	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	9,947	9,947	0	9,947	15.00
16.00	Transportation (Health Care Staff)	0	242	242	0	242	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	10,189	10,189	0	10,189	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	343,461	10,189	353,650	0	353,650	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	1,722	1,722	-1,722	0	29.00
30.00	Administrative Costs	35,067	181,635	216,702	-34,750	181,952	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	35,067	183,357	218,424	-36,472	181,952	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	378,528	193,546	572,074	-36,472	535,602	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1342 | Component CCN: 14-3975 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-1 | Date/Time Prepared: 5/30/2017 11:51 am

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	39,561		1.00
2.00	Physician Assistant	0	199,300		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	104,600		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	343,461		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	9,947		15.00
16.00	Transportation (Health Care Staff)	0	242		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	10,189		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	353,650		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	181,952		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	181,952		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	535,602		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1342 | Component CCN: 14-3975 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-2 | Date/Time Prepared: 5/30/2017 11:51 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.45	0	4,200	1,890		1.00
2.00	Physician Assistant	2.20	7,801	2,100	4,620		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.65	7,801		6,510	7,801	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.65	7,801			7,801	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					353,650	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)					353,650	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					181,952	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					513,918	15.00
16.00	Total overhead (sum of lines 14 and 15)					695,870	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					695,870	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					695,870	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,049,520	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1342 | Component CCN: 14-3975 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-3 | Date/Time Prepared: 5/30/2017 11:51 am

Title XVIII | RHC I | Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	1,049,520	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)	0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	1,049,520	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	7,801	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	7,801	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	134.54	7.00

		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions)	134.54	134.54	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	764	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	102,789	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	102,789	16.00
16.01	Total program charges (see instructions)(from contractor's records)		101,430	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		67,989	16.04
16.05	Total program cost (see instructions)	0	67,989	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		17,803	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		16,725	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		67,989	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		67,989	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		67,989	26.00
26.01	Sequestration adjustment (see instructions)		1,360	26.01
27.00	Interim payments		55,704	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)		10,925	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

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

Provider CCN: 14-1342 | Component CCN: 14-3975 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-5 | Date/Time Prepared: 5/30/2017 11:51 am

RHC I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		55,704	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			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)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		55,704	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		10,925	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		66,629	7.00

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