

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: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/19/2017 6:13 pm
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PART I - COST REPORT STATUS

Provider use only

1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. 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. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 5/19/2017 Time: 6:13 pm

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 GREENVILLE REGIONAL HOSPITAL (14-0137) 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 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-128,153	-7,188	0	0	1.00
2.00 Subprovider - IPF	0	-1	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
10.00 RURAL HEALTH CLINIC I	0		331,370		0	10.00
200.00 Total	0	-128,154	324,182	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: 14-0137		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/19/2017 6:12 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 200 HEALTHCARE DRIVE			PO Box:							1.00	
2.00	City: GREENVILLE			State: IL		Zip Code: 62246-1156		County: BOND			2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
								V	XVIII	XIX		
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		GREENVILLE REGIONAL HOSPITAL	140137	41180	1	07/01/1966	N	P	N	3.00	
4.00	Subprovider - IPF		GREENVILLE I/P PSYCH UNIT	14S137	41180	4	01/01/2005	N	P	N	4.00	
5.00	Subprovider - IRF										5.00	
6.00	Subprovider - (Other)										6.00	
7.00	Swing Beds - SNF		GREENVILLE REGIONAL HOSP- SWING BED	14U137	41180		10/03/2001	N	P	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		GREENVILLE FAMILY WELLNESS	143491	41180		07/24/2007	N	O	N	15.00	
16.00	Hospital-Based Health Clinic - FQHC										16.00	
17.00	Hospital-Based (CMHC) I										17.00	
18.00	Renal Dialysis										18.00	
19.00	Other										19.00	
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2016	12/31/2016		20.00		
21.00	Type of Control (see instructions)						2			21.00		
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickles amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	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)						Y	Y		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 days	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.			786	0	0	0	575	0		24.00	

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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00	
		Urban/Rural		S		Date of Geogr			
		1.00		2.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		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.					1		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 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)					N		37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
		Y/N		Y/N					
		1.00		2.00					
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					Y	Y	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	Y	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.					N			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			
		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0137

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

Worksheet S-2
Part I
Date/Time Prepared:
5/19/2017 6:12 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00	

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N		0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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				1.00	
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a critical access hospital (CAH)?		N		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. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				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
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:	460,842	557		0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/19/2017 6:12 pm	
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02	
119.00	DO NOT USE THIS LINE			119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00	
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00	
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00	
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	148005	140.00	
		1.00	2.00	3.00	
141.00	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. Name: HOSPITAL SISTERS HEALTH SYSTEM Contractor's Name: NATIONAL GOVERNMENT SERVICES Contractor's Number: 00131			141.00	
142.00	Street: 4936 LAVERNA ROAD PO Box:			142.00	
143.00	City: SPRINGFIELD State: IL Zip Code: 62794			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
155.00	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)	N	N	N	N
156.00	Hospital	N	N	N	N
157.00	Subprovider - IPF	N	N	N	N
158.00	Subprovider - IRF	N	N	N	N
159.00	SUBPROVIDER	N	N	N	N
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC	N	N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0137			Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/19/2017 6:12 pm		
							1.00		
Multi campus									
165.00	Is this hospital part of a Multi campus 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)						41180	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.						N		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)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
		Beginning	Ending						
		1.00	2.00						
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								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. 1, 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		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0137		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part II Date/Time Prepared: 5/19/2017 6:12 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
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				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/17/2017	Y	04/17/2017		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/19/2017 6:12 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA		RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544		PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0137

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

Worksheet S-2
Part II
Date/Time Prepared:
5/19/2017 6:12 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR	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: 14-0137

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

Worksheet S-3
Part I
Date/Time Prepared:
5/19/2017 6:12 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				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	32	11,712	0.00	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)		32	11,712	0.00	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	43.00				0	13.00
14.00 Total (see instructions)		32	11,712	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,660		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		42				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: 14-0137

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

Worksheet S-3
Part I
Date/Time Prepared:
5/19/2017 6:12 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	775	546	2,338			1.00
2.00 HMO and other (see instructions)	65	575				2.00
3.00 HMO IPF Subprovider	154	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	675	0	675			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	159			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,450	546	3,172			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		190	357			13.00
14.00 Total (see instructions)	1,450	736	3,529	0.00	196.12	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,319	67	1,699	0.00	16.84	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00 NURSING FACILITY		0	0	0.00	0.00	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	5,570	0	19,917	0.00	15.20	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	228.16	27.00
28.00 Observation Bed Days		39	233			28.00
29.00 Ambulance Trips	650					29.00
30.00 Employee discount days (see instruction)			9			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	50	91			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: 14-0137

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

Worksheet S-3
Part I
Date/Time Prepared:
5/19/2017 6:12 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	299	483	1,007	1.00
2.00 HMO and other (see instructions)			29	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	299	483	1,007	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	160	12	221	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY	0.00					20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	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 WAGE INDEX INFORMATION

Provider CCN: 14-0137

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

Worksheet S-3
Part II
Date/Time Prepared:
5/19/2017 6:12 pm

	Worksheet A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 + col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	11,359,400	0	11,359,400	474,575.25	23.94
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	436,372	436,372	4,380.00	99.63
4.00	Physician-Part A - Administrative		1,500	0	1,500	14.75	101.69
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		285,639	0	285,639	4,576.00	62.42
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		588,112	0	588,112	32,055.68	18.35
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,520,530	0	1,520,530	71,182.50	21.36
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		1,529,969	0	1,529,969	25,830.00	59.23
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		115,500	0	115,500	758.84	152.21
14.00	Home office and/or related organization salaries and wage-related costs		868,364	0	868,364	12,508.71	69.42
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		2,161,465	0	2,161,465		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		411,523	0	411,523		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		54,315	0	54,315		
22.00	Physician Part A - Administrative		185	0	185		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		42,436	0	42,436		
24.00	Wage-related costs (RHC/FQHC)		177,149	0	177,149		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related		0	0	0		
25.51	Related organization wage-related		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	173,569	0	173,569	4,192.25	41.40
27.00	Administrative & General	5.00	1,497,832	0	1,497,832	55,753.37	26.87

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0137

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

Worksheet S-3
Part II
Date/Time Prepared:
5/19/2017 6:12 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	10,210	0	10,210	592.50	17.23	28.00
29.00	Maintenance & Repairs	281,224	0	281,224	10,890.52	25.82	29.00
30.00	Operation of Plant	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	367,339	0	367,339	33,022.85	11.12	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	392,219	-268,436	123,783	9,193.66	13.46	34.00
35.00	Dietary under contract (see instructions)	8,697	0	8,697	908.50	9.57	35.00
36.00	Cafeteria	0	268,436	268,436	19,937.32	13.46	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	692,711	0	692,711	22,472.32	30.83	38.00
39.00	Central Services and Supply	120,121	0	120,121	6,143.00	19.55	39.00
40.00	Pharmacy	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	234,300	0	234,300	12,106.98	19.35	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0137

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

Worksheet S-3
Part III
Date/Time Prepared:
5/19/2017 6:12 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	10,504,556	-436,372	10,068,184	435,064.57	23.14	1.00
2.00	Excluded area salaries (see instructions)	1,520,530	0	1,520,530	71,182.50	21.36	2.00
3.00	Subtotal salaries (line 1 minus line 2)	8,984,026	-436,372	8,547,654	363,882.07	23.49	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,513,833	0	2,513,833	39,097.55	64.30	4.00
5.00	Subtotal wage-related costs (see inst.)	2,161,650	0	2,161,650	0.00	25.29	5.00
6.00	Total (sum of lines 3 thru 5)	13,659,509	-436,372	13,223,137	402,979.62	32.81	6.00
7.00	Total overhead cost (see instructions)	3,778,222	0	3,778,222	175,213.27	21.56	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part IV Date/Time Prepared: 5/19/2017 6:12 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		105,145	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		7,560	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		1,489,046	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		148,479	9.00
10.00	Dental, Hearing and Vision Plan		34,701	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		52,934	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		200,823	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		624,931	17.00
18.00	Medicare Taxes - Employers Portion Only		164,711	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		12,989	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		5,664	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		2,846,983	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0137

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

Worksheet S-3
Part V
Date/Time Prepared:
5/19/2017 6:12 pm

Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,540,951	0	1.00
2.00	Hospital	1,529,969	0	2.00
3.00	Subprovider - IPF	10,982	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0137

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

Worksheet S-7
Date/Time Prepared:
5/19/2017 6:12 pm

		1.00	2.00		
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.				2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	19	19 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	6	6 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	0	20	20 13.00
14.00		RUA	0	13	13 14.00
15.00		RVC	0	20	20 15.00
16.00		RVB	0	19	19 16.00
17.00		RVA	0	139	139 17.00
18.00		RHC	0	0	0 18.00
19.00		RHB	0	170	170 19.00
20.00		RHA	0	168	168 20.00
21.00		RMC	0	14	14 21.00
22.00		RMB	0	0	0 22.00
23.00		RMA	0	28	28 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	14	14 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	6	6 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	0	19	19 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	4	4 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	0	0	0 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	0	0	0 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	0	0	0 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	0	14	14 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0137

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

Worksheet S-7

Date/Time Prepared:
5/19/2017 6:12 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	2	2	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	675	675	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).		41180	41180	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0137 Component CCN: 14-3491	Period: From 01/01/2016 To 12/31/2016	Worksheet S-8 Date/Time Prepared: 5/19/2017 6:12 pm	
		RHC I	Cost		
		1.00			
1.00	Clinic Address and Identification Street	150 HEALTHCARE DRIVE			1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	GREENVILLE	IL	62246	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	
4.00 Source of Federal Funds					4.00
5.00 Community Health Center (Section 330(d), PHS Act)					5.00
6.00 Migrant Health Center (Section 329(d), PHS Act)					6.00
7.00 Health Services for the Homeless (Section 340(d), PHS Act)					7.00
8.00 Appalachian Regional Commission					8.00
9.00 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
		1.00	2.00	3.00	4.00
11.00	Facility hours of operations (1) Clinic	08:00		17:00	08:00
		1.00			2.00
12.00	Have you received an approval for an exception to the productivity standard?	N			12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y			5 13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number	GREENVILLE FAMILY WELLNESS		143491	14.00
14.01		MCCRACKEN DAWDY HALL FAMILY PRACTICE		148519	14.01
14.02		MCCRACKEN DAWDY HALL FAMILY PRACTICE		148520	14.02
14.03		GREENVILLE MEDICAL ASSOCIATES		148513	14.03
14.04		CONVENIENT CARE		148545	14.04
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
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)				5.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0137 Component CCN: 14-3491		Period: From 01/01/2016 To 12/31/2016		Worksheet S-8 Date/Time Prepared: 5/19/2017 6:12 pm		
		RHC I		Cost				
		County						
		4.00						
2.00	City, State, ZIP Code, County	BOND						2.00
		Tuesday		Wednesday		Thursday		
		to		to		to		
		6.00		7.00		8.00		
		9.00		10.00				
Facility hours of operations (1)								
11.00	Clinic	17:00	08:00	17:00	08:00	17:00	11.00	
		Friday		Saturday				
		from		from		to		
		11.00		12.00		13.00		
		14.00						
Facility hours of operations (1)								
11.00	Clinic	08:00	17:00	08:00	12:00		11.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet S-10 Date/Time Prepared: 5/19/2017 6:12 pm
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			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)		0.409043	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,172,015	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		1,656,810	5.00	
6.00	Medicaid charges		12,527,284	6.00	
7.00	Medicaid cost (line 1 times line 6)		5,124,198	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		2,295,373	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		2,295,373	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)		230,973	337,581	568,554
21.00	Cost of patients approved for charity care (line 1 times line 20)		94,478	138,085	232,563
22.00	Partial payment by patients approved for charity care		4,169	3,058	7,227
23.00	Cost of charity care (line 21 minus line 22)		90,309	135,027	225,336
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,872,014		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		141,356		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		1,730,658		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		707,914		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		933,250		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,228,623		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 14-0137		Period: From 01/01/2016 To 12/31/2016		Worksheet A		
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,062,059	1,062,059	-317,696	744,363	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		604,447	604,447	610,684	1,215,131	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	173,569	2,883,149	3,056,718	0	3,056,718	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,497,832	3,386,699	4,884,531	-254,104	4,630,427	5.00
6.00	00600	MAINTENANCE & REPAIRS	281,224	988,228	1,269,452	0	1,269,452	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	93,253	93,253	0	93,253	8.00
9.00	00900	HOUSEKEEPING	367,339	61,319	428,658	0	428,658	9.00
10.00	01000	DIETARY	392,219	252,900	645,119	-441,521	203,598	10.00
11.00	01100	CAFETERIA	0	0	0	441,521	441,521	11.00
13.00	01300	NURSING ADMINISTRATION	692,711	104,417	797,128	0	797,128	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	120,121	53,542	173,663	0	173,663	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	234,300	215,862	450,162	0	450,162	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	576,344	576,344	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,415,354	1,179,170	2,594,524	-500,089	2,094,435	30.00
40.00	04000	SUBPROVIDER - I/PF	696,951	110,505	807,456	0	807,456	40.00
43.00	04300	NURSERY	0	0	0	399,184	399,184	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	635,356	304,589	939,945	0	939,945	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	100,905	100,905	52.00
53.00	05300	ANESTHESIOLOGY	436,372	139,972	576,344	-576,344	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	564,721	558,602	1,123,323	0	1,123,323	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	583,132	886,609	1,469,741	0	1,469,741	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	322,250	24,415	346,665	-79,152	267,513	65.00
66.00	06600	PHYSICAL THERAPY	0	1,078,960	1,078,960	-310,264	768,696	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	197,723	197,723	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	112,541	112,541	68.00
69.00	06900	ELECTROCARDIOLOGY	0	48,519	48,519	79,152	127,671	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	360,065	360,065	0	360,065	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	79,378	79,378	0	79,378	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	460,829	1,001,731	1,462,560	0	1,462,560	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	132,403	52,506	184,909	0	184,909	75.01
76.97	07697	CARDIAC REHABILITATION	14,542	1,216	15,758	0	15,758	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	873,751	2,592,912	3,466,663	226,053	3,692,716	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	640,845	1,012,276	1,653,121	0	1,653,121	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	575,661	65,085	640,746	0	640,746	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	264,937	264,937	-264,937	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,111,482	19,467,322	30,578,804	0	30,578,804	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	159,352	267,987	427,339	0	427,339	192.00
193.00	19300	NONPAID WORKERS	28,559	14,878	43,437	0	43,437	193.00
194.00	07950	EMERALD POINT	60,007	259,120	319,127	0	319,127	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	11,359,400	20,009,307	31,368,707	0	31,368,707	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0137

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

Worksheet A
Date/Time Prepared:
5/19/2017 6:12 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	607,298	1,351,661	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-6,832	1,208,299	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-657,345	2,399,373	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-712,210	3,918,217	5.00
6.00	00600	MAINTENANCE & REPAIRS	-12,263	1,257,189	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	93,253	8.00
9.00	00900	HOUSEKEEPING	0	428,658	9.00
10.00	01000	DIETARY	-1,960	201,638	10.00
11.00	01100	CAFETERIA	-137,620	303,901	11.00
13.00	01300	NURSING ADMINISTRATION	-530	796,598	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-551	173,112	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,469	443,693	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-576,344	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-688,163	1,406,272	30.00
40.00	04000	SUBPROVIDER - IPF	-42,579	764,877	40.00
43.00	04300	NURSERY	0	399,184	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	939,945	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	100,905	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-591	1,122,732	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-17,709	1,452,032	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	267,513	65.00
66.00	06600	PHYSICAL THERAPY	-2	768,694	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	197,723	67.00
68.00	06800	SPEECH PATHOLOGY	0	112,541	68.00
69.00	06900	ELECTROCARDIOLOGY	-37,730	89,941	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	-515	359,550	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	79,378	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-163,486	1,299,074	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	-9,561	175,348	75.01
76.97	07697	CARDIAC REHABILITATION	0	15,758	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-211,705	3,481,011	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-936,815	716,306	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-17,016	623,730	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,630,698	26,948,106	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	108,217	535,556	192.00
193.00	19300	NONPAID WORKERS	0	43,437	193.00
194.00	07950	EMERALD POINT	140,456	459,583	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	-3,382,025	27,986,682	200.00

RECLASSIFICATIONS

Provider CCN: 14-0137

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

Worksheet A-6

Date/Time Prepared:
5/19/2017 6:12 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CRNA FEES					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	436,372	139,972	1.00
	O		436,372	139,972	
B - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	268,436	173,085	1.00
	O		268,436	173,085	
C - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	589,815	1.00
	TOTALS		0	589,815	
D - EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	79,152	0	1.00
	O		79,152	0	
E - OB EXPENSE					
1.00	NURSERY	43.00	266,782	132,402	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	67,437	33,468	2.00
	O		334,219	165,870	
F - CONTRACT THERAPY EXPENSE					
1.00	OCCUPATIONAL THERAPY	67.00	0	197,723	1.00
2.00	SPEECH PATHOLOGY	68.00	0	112,541	2.00
	O		0	310,264	
G - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	28,051	1.00
	O		0	28,051	
H - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	248,997	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	15,940	2.00
	O		0	264,937	
I - TO RECLASSIFY ALLOWABLE PORTION OF M					
1.00	RURAL HEALTH CLINIC	88.00	0	226,053	1.00
	TOTALS		0	226,053	
500.00	Grand Total: Increases		1,118,179	1,898,047	500.00

RECLASSIFICATIONS

Provider CCN: 14-0137

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

Worksheet A-6

Date/Time Prepared:
5/19/2017 6:12 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CRNA FEES						
1.00	ANESTHESIOLOGY	53.00	436,372	139,972	0		1.00
	O		436,372	139,972			
	B - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	268,436	173,085	0		1.00
	O		268,436	173,085			
	C - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	589,815	9		1.00
	TOTALS		0	589,815			
	D - EKG SALARIES						
1.00	RESPIRATORY THERAPY	65.00	79,152	0	0		1.00
	O		79,152	0			
	E - OB EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	334,219	165,870	0		1.00
2.00	O	0.00	0	0	0		2.00
	O		334,219	165,870			
	F - CONTRACT THERAPY EXPENSE						
1.00	PHYSICAL THERAPY	66.00	0	310,264	0		1.00
2.00	O	0.00	0	0	0		2.00
	O		0	310,264			
	G - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	28,051	0		1.00
	O		0	28,051			
	H - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	264,937	11		1.00
2.00	O	0.00	0	0	11		2.00
	O		0	264,937			
	I - TO RECLASSIFY ALLOWABLE PORTION OF M						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	226,053	0		1.00
	TOTALS		0	226,053			
500.00	Grand Total: Decreases		1,118,179	1,898,047			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0137

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

Worksheet A-7
Part I
Date/Time Prepared:
5/19/2017 6:12 pm

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	1,540,441	0	1,540,441	0	1.00
2.00	Land Improvements	1,363,427	0	0	0	963,427	2.00
3.00	Buildings and Fixtures	31,806,783	0	0	0	25,612,302	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	9,770,677	0	0	0	8,444,510	6.00
7.00	HIT designated Assets	0	407,937	0	407,937	0	7.00
8.00	Subtotal (sum of lines 1-7)	42,940,887	1,948,378	0	1,948,378	35,020,239	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	42,940,887	1,948,378	0	1,948,378	35,020,239	10.00
	Ending Balance		Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,540,441	0				1.00
2.00	Land Improvements	400,000	0				2.00
3.00	Buildings and Fixtures	6,194,481	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	1,326,167	0				6.00
7.00	HIT designated Assets	407,937	0				7.00
8.00	Subtotal (sum of lines 1-7)	9,869,026	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	9,869,026	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0137

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

Worksheet A-7
Part II
Date/Time Prepared:
5/19/2017 6:12 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	989,275	61,796	0	0	10,988	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	604,447	0	0	0	2.00
3.00	Total (sum of lines 1-2)	989,275	666,243	0	0	10,988	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,062,059				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	604,447				2.00
3.00	Total (sum of lines 1-2)	0	1,666,506				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0137

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

Worksheet A-7
Part III
Date/Time Prepared:
5/19/2017 6:12 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	8,134,922	0	8,134,922	0.824288	23,122	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,734,104	0	1,734,104	0.175712	4,929	2.00
3.00	Total (sum of lines 1-2)	9,869,026	0	9,869,026	1.000000	28,051	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	23,122	1,035,033	61,796	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	4,929	584,471	604,447	2.00
3.00	Total (sum of lines 1-2)	0	0	28,051	1,619,504	666,243	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	220,722	23,122	10,988	0	1,351,661	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,452	4,929	0	0	1,208,299	2.00
3.00	Total (sum of lines 1-2)	235,174	28,051	10,988	0	2,559,960	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0137

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

Worksheet A-8

Date/Time Prepared:
5/19/2017 6:12 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-28,275	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-1,488	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-2,353	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	B	-12,263	MAINTENANCE & REPAIRS	6.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,973,013			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	452,853			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-137,620	CAFETERIA	11.00	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	B	-161,143	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00 Sale of medical records and abstracts	B	-6,469	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	B	-1,558	DIETARY	10.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist	A	-576,344	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	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 COUNTRY CLUB DUES	A	-1,125	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01 CRNA RELATED BENEFITS	A	-39,964	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0137

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

Worksheet A-8

Date/Time Prepared:
5/19/2017 6:12 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
35.00 LOBBYING EXPENSE	A	-16,363	ADMINISTRATIVE & GENERAL		5.00	0 35.00
44.00 ADVERTISING OFFSET	A	-100,661	ADMINISTRATIVE & GENERAL		5.00	0 44.00
45.00		0			0.00	0 45.00
45.01 AMBULANCE REIMBURSEMENT	B	-17,016	AMBULANCE SERVICES		95.00	0 45.01
45.02 EDUCATION SEMINARS	B	-530	NURSING ADMINISTRATION		13.00	0 45.02
45.03 HEALTH FAIR COSTS	A	-98,984	ADMINISTRATIVE & GENERAL		5.00	0 45.03
45.04		0			0.00	0 45.04
45.05 PROVIDER TAX	A	-781,607	ADMINISTRATIVE & GENERAL		5.00	0 45.05
45.06		0			0.00	0 45.06
45.07 VARIOUS ADMINISTRATIVE	B	-183	ADMINISTRATIVE & GENERAL		5.00	0 45.07
45.08 MISC REVENUE	B	-35,887	ADMINISTRATIVE & GENERAL		5.00	9 45.08
45.09 SELF INSURANCE ADJUSTMENT	A	-617,381	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 45.09
45.10 RENT	B	-250	RADIOLOGY-DIAGNOSTIC		54.00	0 45.10
45.11 COMMUNITY HEALTH EVENTS INCOME	B	-4,040	LABORATORY		60.00	0 45.11
45.13 MISC REVENUE	B	-40	RURAL HEALTH CLINIC		88.00	0 45.13
45.14 TELEPHONE SERVICE	A	-5,344	CAP REL COSTS-MVBLE EQUIP		2.00	9 45.14
45.16 TELEPHONE SERVICE	A	-3,935	ADMINISTRATIVE & GENERAL		5.00	0 45.16
45.17 TELEPHONE SERVICE	A	-318	CAP REL COSTS-BLDG & FIXT		1.00	9 45.17
45.23 CATERING REVENUE	B	-402	DIETARY		10.00	0 45.23
45.25 MISC REVENUE	B	-22	LABORATORY		60.00	0 45.25
45.27 MISC SUPPLY REVENUE	B	-2,343	DRUGS CHARGED TO PATIENTS		73.00	0 45.27
45.28 MISC SUPPLY REVENUE	B	-515	MEDICAL SUPPLIES CHARGED TO PAT		71.00	0 45.28
45.29 MANAGEMENT FEES	A	-21,979	ADMINISTRATIVE & GENERAL		5.00	0 45.29
46.00 REVALUED ASSETS DEPRECIATION	A	567,399	CAP REL COSTS-BLDG & FIXT		1.00	9 46.00
46.01 REVALUED ASSETS DEPRECIATION	A	108,217	PHYSICIANS PRIVATE OFFICES		192.00	0 46.01
46.02 REVALUED ASSETS DEPRECIATION	A	140,456	EMERALD POINT		194.00	0 46.02
46.03 LATE FEES	A	-2	PHYSICAL THERAPY		66.00	0 46.03
46.04 LATE FEES	A	-551	CENTRAL SERVICES & SUPPLY		14.00	0 46.04
46.05 LATE FEES -ACCTNG	A	-54	ADMINISTRATIVE & GENERAL		5.00	0 46.05
46.06 ALCHOLIC BEVERAGES	A	-412	ADMINISTRATIVE & GENERAL		5.00	0 46.06
46.07 FOOD COSTS FOR ADMINISTRATION	A	-516	ADMINISTRATIVE & GENERAL		5.00	0 46.07
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,382,025				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: 14-0137

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

Worksheet A-8-1

Date/Time Prepared:
5/19/2017 6:12 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	GFW RHC LEASE EXPENSE	19,001	14,850 1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	GMA RHC LEASE EXPENSE	17,528	1,200 2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	MDH RHC LEASE EXPENSE	42,177	0 3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	MDH POKEY RHC LEASE EXPENSE	5,836	0 4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	IT CONTRACT SERVICES ISC	804,478	532,739 4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	ADMIN CONTRACT SERVICES SSC	112,622	0 4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,001,642	548,789 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.

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			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	GREENVILLE REGI	100.00	0.00	6.00
7.00			0.00	0.00	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: 14-0137

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

Worksheet A-8-1

Date/Time Prepared:
5/19/2017 6:12 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	4,151	9		1.00
2.00	16,328	9		2.00
3.00	42,177	9		3.00
4.00	5,836	9		4.00
4.01	271,739	0		4.01
4.02	112,622	0		4.02
5.00	452,853			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0137

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

Worksheet A-8-2

Date/Time Prepared:
5/19/2017 6:12 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	54.00	RADIOLOGY-DIAGNOSTIC	341	341	0	0	0	1.00
2.00	90.00	CLINIC	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	37,730	37,730	0	0	0	3.00
4.00	91.00	EMERGENCY	936,815	936,815	0	0	0	4.00
5.00	60.00	LABORATORY	13,647	13,647	0	0	0	5.00
6.00	40.00	SUBPROVIDER - IPF	79,623	7,623	72,000	181,300	425	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	8.00
9.00	5.00	ADMINISTRATIVE & GENERAL	32,512	32,512	0	0	0	9.00
10.00	30.00	ADULTS & PEDIATRICS	688,163	688,163	0	0	0	10.00
11.00	50.00	OPERATING ROOM	0	0	0	0	0	11.00
12.00	75.01	SNR DAY TREATMENT- WHITE OAKS	24,000	0	24,000	211,500	142	12.00
13.00	88.00	RURAL HEALTH CLINIC	211,665	211,665	0	0	0	13.00
200.00			2,024,496	1,928,496	96,000		567	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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	1.00
2.00	90.00	CLINIC	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	40.00	SUBPROVIDER - IPF	37,044	1,852	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	8.00
9.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	9.00
10.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	10.00
11.00	50.00	OPERATING ROOM	0	0	0	0	0	11.00
12.00	75.01	SNR DAY TREATMENT- WHITE OAKS	14,439	722	0	0	0	12.00
13.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	13.00
200.00			51,483	2,574	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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	341		1.00
2.00	90.00	CLINIC	0	0	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	37,730		3.00
4.00	91.00	EMERGENCY	0	0	0	936,815		4.00
5.00	60.00	LABORATORY	0	0	0	13,647		5.00
6.00	40.00	SUBPROVIDER - IPF	0	37,044	34,956	42,579		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0		7.00
8.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0		8.00
9.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	32,512		9.00
10.00	30.00	ADULTS & PEDIATRICS	0	0	0	688,163		10.00
11.00	50.00	OPERATING ROOM	0	0	0	0		11.00
12.00	75.01	SNR DAY TREATMENT- WHITE OAKS	0	14,439	9,561	9,561		12.00
13.00	88.00	RURAL HEALTH CLINIC	0	0	0	211,665		13.00
200.00			0	51,483	44,517	1,973,013		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0137

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

Worksheet B
Part I
Date/Time Prepared:
5/19/2017 6:12 pm

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	1,351,661	1,351,661			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,208,299		1,208,299		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,399,373	2,787	2,491	2,404,651	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,918,217	338,838	302,901	331,133	5.00
6.00 00600	MAINTENANCE & REPAIRS	1,257,189	109,815	98,167	63,029	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	93,253	19,151	17,119	0	8.00
9.00 00900	HOUSEKEEPING	428,658	17,767	15,883	82,330	9.00
10.00 01000	DIETARY	201,638	33,430	29,884	87,906	10.00
11.00 01100	CAFETERIA	303,901	9,309	8,321	60,163	11.00
13.00 01300	NURSING ADMINISTRATION	796,598	20,020	17,897	95,091	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	173,112	61,879	55,316	26,922	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	443,693	28,568	25,538	52,512	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,406,272	94,696	84,652	242,309	30.00
40.00 04000	SUBPROVIDER - IPF	764,877	44,329	39,627	156,204	40.00
43.00 04300	NURSERY	399,184	2,362	2,111	59,793	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	939,945	82,996	74,193	142,399	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	100,905	10,000	8,940	15,114	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,122,732	57,818	51,685	126,568	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	1,452,032	25,080	22,420	130,694	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	267,513	15,633	13,975	54,484	65.00
66.00 06600	PHYSICAL THERAPY	768,694	43,845	39,195	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	197,723	12,194	10,901	0	67.00
68.00 06800	SPEECH PATHOLOGY	112,541	5,850	5,229	0	68.00
69.00 06900	ELECTROCARDIOLOGY	89,941	1,265	1,131	17,740	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	359,550	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	79,378	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,299,074	16,236	14,514	103,283	73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01 07501	SNR DAY TREATMENT- WHITE OAKS	175,348	19,941	17,826	29,675	75.01
76.97 07697	CARDIAC REHABILITATION	15,758	3,913	3,498	3,259	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	3,481,011	185,745	166,045	195,829	88.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	716,306	22,570	20,176	143,629	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	623,730	20,406	18,241	129,020	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	26,948,106	1,306,443	1,167,876	2,349,086	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	190.00
192.00 19200	PHYSICIANS PRIVATE OFFICES	535,556	39,744	35,529	35,715	192.00
193.00 19300	NONPAID WORKERS	43,437	5,474	4,894	6,401	193.00
194.00 07950	EMERALD POINT	459,583	0	0	13,449	194.00
194.01 07951	CONVENIENT CARE PRE-RHC	0	0	0	0	194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	27,986,682	1,351,661	1,208,299	2,404,651	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0137

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

Worksheet B
Part I
Date/Time Prepared:
5/19/2017 6:12 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	4,891,089					5.00
6.00	00600	323,636	1,851,836				6.00
8.00	00800	27,430	39,395	196,348			8.00
9.00	00900	115,341	36,549	453	696,981		9.00
10.00	01000	74,727	68,768	8,001	26,989	531,343	10.00
11.00	01100	80,834	19,149	1,507	7,515	0	11.00
13.00	01300	196,868	41,184	0	16,163	0	13.00
14.00	01400	67,181	127,291	673	49,958	0	14.00
16.00	01600	116,543	58,767	0	23,064	0	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	387,111	194,799	55,001	76,452	217,034	30.00
40.00	04000	212,843	91,189	32,421	35,789	76,444	40.00
43.00	04300	98,148	4,858	8,934	1,907	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	262,503	170,731	24,391	67,006	0	50.00
52.00	05200	28,581	20,571	2,259	8,074	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	287,762	118,936	8,983	46,679	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	345,243	51,591	7,976	20,248	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	74,462	32,158	4,888	12,621	0	65.00
66.00	06600	180,377	90,193	0	35,398	0	66.00
67.00	06700	46,764	25,084	0	9,845	0	67.00
68.00	06800	26,180	12,034	0	4,723	0	68.00
69.00	06900	23,312	2,602	0	1,021	0	69.00
71.00	07100	76,144	0	0	0	0	71.00
72.00	07200	16,810	0	0	0	0	72.00
73.00	07300	303,498	33,398	0	13,108	0	73.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	51,417	41,021	0	16,099	0	75.01
76.97	07697	5,597	8,050	10,906	3,159	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	853,162	382,096	1,715	149,960	0	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	191,166	46,428	21,111	18,222	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	167,599	41,976	5,133	16,474	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		4,641,239	1,758,818	194,352	660,474	293,478	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	136,923	81,757	1,287	32,087	0	192.00
193.00	19300	12,750	11,261	0	4,420	0	193.00
194.00	07950	100,177	0	709	0	237,865	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		4,891,089	1,851,836	196,348	696,981	531,343	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0137

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		11.00	13.00	14.00	16.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	490,699					11.00
13.00	01300	32,701	1,216,522				13.00
14.00	01400	8,939	0	571,271			14.00
16.00	01600	17,618	0	1,738	768,041		16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	71,721	227,252	17,604	36,455	0	30.00
40.00	04000	50,972	161,515	4,414	21,817	0	40.00
43.00	04300	14,760	46,770	3,911	3,654	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	35,473	112,403	49,092	55,767	0	50.00
52.00	05200	3,731	11,823	989	6,886	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	30,742	97,413	32,392	206,876	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	36,415	115,386	190,264	148,551	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	15,770	49,970	7,168	16,482	0	65.00
66.00	06600	0	0	6,901	55,357	0	66.00
67.00	06700	0	0	0	7,336	0	67.00
68.00	06800	0	0	0	1,051	0	68.00
69.00	06900	4,924	15,604	0	14,530	0	69.00
71.00	07100	0	0	139,156	14,056	0	71.00
72.00	07200	0	0	30,678	3,463	0	72.00
73.00	07300	18,907	59,911	0	79,904	0	73.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	8,631	27,348	462	4,083	0	75.01
76.97	07697	995	3,154	453	1,805	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	46,007	0	48,394	0	0	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	39,780	126,052	9,542	62,406	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	39,114	123,940	12,807	27,562	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		477,200	1,178,541	555,965	768,041	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	7,117	22,553	692	0	0	192.00
193.00	19300	1,513	0	499	0	0	193.00
194.00	07950	4,869	15,428	14,115	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		490,699	1,216,522	571,271	768,041	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0137

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
16.00	01600				16.00
19.00	01900				19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	3,111,358	0	3,111,358	30.00
40.00	04000	1,692,441	0	1,692,441	40.00
43.00	04300	646,392	0	646,392	43.00
44.00	04400	0	0	0	44.00
45.00	04500	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	2,016,899	0	2,016,899	50.00
52.00	05200	217,873	0	217,873	52.00
53.00	05300	0	0	0	53.00
54.00	05400	2,188,586	0	2,188,586	54.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	2,545,900	0	2,545,900	60.00
60.01	06001	0	0	0	60.01
65.00	06500	565,124	0	565,124	65.00
66.00	06600	1,219,960	0	1,219,960	66.00
67.00	06700	309,847	0	309,847	67.00
68.00	06800	167,608	0	167,608	68.00
69.00	06900	172,070	0	172,070	69.00
71.00	07100	588,906	0	588,906	71.00
72.00	07200	130,329	0	130,329	72.00
73.00	07300	1,941,833	0	1,941,833	73.00
75.00	07500	0	0	0	75.00
75.01	07501	391,851	0	391,851	75.01
76.97	07697	60,547	0	60,547	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	5,509,964	0	5,509,964	88.00
90.00	09000	0	0	0	90.00
91.00	09100	1,417,388	0	1,417,388	91.00
92.00	09200	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	1,226,002	0	1,226,002	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	0	0	0	113.00
118.00		26,120,878	0	26,120,878	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
192.00	19200	928,960	0	928,960	192.00
193.00	19300	90,649	0	90,649	193.00
194.00	07950	846,195	0	846,195	194.00
194.01	07951	0	0	0	194.01
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		27,986,682	0	27,986,682	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0137

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

Worksheet B
Part II
Date/Time Prepared:
5/19/2017 6:12 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	2.00			
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	2,787	2,491	5,278	5,278 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	338,838	302,901	641,739	726 5.00
6.00 00600	MAINTENANCE & REPAIRS	0	109,815	98,167	207,982	138 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	19,151	17,119	36,270	0 8.00
9.00 00900	HOUSEKEEPING	0	17,767	15,883	33,650	181 9.00
10.00 01000	DIETARY	0	33,430	29,884	63,314	193 10.00
11.00 01100	CAFETERIA	0	9,309	8,321	17,630	132 11.00
13.00 01300	NURSING ADMINISTRATION	0	20,020	17,897	37,917	209 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	61,879	55,316	117,195	59 14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	28,568	25,538	54,106	115 16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	94,696	84,652	179,348	532 30.00
40.00 04000	SUBPROVIDER - IPF	0	44,329	39,627	83,956	343 40.00
43.00 04300	NURSERY	0	2,362	2,111	4,473	131 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
45.00 04500	NURSING FACILITY	0	0	0	0	0 45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	82,996	74,193	157,189	313 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	10,000	8,940	18,940	33 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	57,818	51,685	109,503	278 54.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MRI	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	0	25,080	22,420	47,500	287 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00 06500	RESPIRATORY THERAPY	0	15,633	13,975	29,608	120 65.00
66.00 06600	PHYSICAL THERAPY	0	43,845	39,195	83,040	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	12,194	10,901	23,095	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	5,850	5,229	11,079	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	1,265	1,131	2,396	39 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	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	16,236	14,514	30,750	227 73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
75.01 07501	SNR DAY TREATMENT- WHITE OAKS	0	19,941	17,826	37,767	65 75.01
76.97 07697	CARDIAC REHABILITATION	0	3,913	3,498	7,411	7 76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	185,745	166,045	351,790	430 88.00
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	0	22,570	20,176	42,746	315 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	20,406	18,241	38,647	283 95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,306,443	1,167,876	2,474,319	5,156 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS PRIVATE OFFICES	0	39,744	35,529	75,273	78 192.00
193.00 19300	NONPAID WORKERS	0	5,474	4,894	10,368	14 193.00
194.00 07950	EMERALD POINT	153,724	0	0	153,724	30 194.00
194.01 07951	CONVENIENT CARE PRE-RHC	0	0	0	0	0 194.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers				0	201.00
202.00	TOTAL (sum lines 118-201)	153,724	1,351,661	1,208,299	2,713,684	5,278 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/19/2017 6:12 pm		
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		5.00	6.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500	642,465				5.00
6.00	00600	42,511	250,631			6.00
8.00	00800	3,603	5,332	45,205		8.00
9.00	00900	15,151	4,947	104	54,033	9.00
10.00	01000	9,816	9,307	1,842	2,092	86,564
11.00	01100	10,618	2,592	347	583	0
13.00	01300	25,860	5,574	0	1,253	0
14.00	01400	8,825	17,228	155	3,873	0
16.00	01600	15,309	7,954	0	1,788	0
19.00	01900	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	50,849	26,364	12,665	5,927	35,358
40.00	04000	27,958	12,342	7,464	2,775	12,454
43.00	04300	12,892	658	2,057	148	0
44.00	04400	0	0	0	0	0
45.00	04500	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	34,481	23,107	5,615	5,195	0
52.00	05200	3,754	2,784	520	626	0
53.00	05300	0	0	0	0	0
54.00	05400	37,799	16,097	2,068	3,619	0
57.00	05700	0	0	0	0	0
58.00	05800	0	0	0	0	0
59.00	05900	0	0	0	0	0
60.00	06000	45,350	6,982	1,836	1,570	0
60.01	06001	0	0	0	0	0
65.00	06500	9,781	4,352	1,125	978	0
66.00	06600	23,694	12,207	0	2,744	0
67.00	06700	6,143	3,395	0	763	0
68.00	06800	3,439	1,629	0	366	0
69.00	06900	3,062	352	0	79	0
71.00	07100	10,002	0	0	0	0
72.00	07200	2,208	0	0	0	0
73.00	07300	39,866	4,520	0	1,016	0
75.00	07500	0	0	0	0	0
75.01	07501	6,754	5,552	0	1,248	0
76.97	07697	735	1,089	2,511	245	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	112,059	51,713	395	11,624	0
90.00	09000	0	0	0	0	0
91.00	09100	25,111	6,284	4,860	1,413	0
92.00	09200					0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	22,015	5,681	1,182	1,277	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
118.00		609,645	238,042	44,746	51,202	47,812
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	0
192.00	19200	17,986	11,065	296	2,488	0
193.00	19300	1,675	1,524	0	343	0
194.00	07950	13,159	0	163	0	38,752
194.01	07951	0	0	0	0	0
200.00						200.00
201.00		0	0	0	0	0
202.00		642,465	250,631	45,205	54,033	86,564

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0137

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

Worksheet B
Part II
Date/Time Prepared:
5/19/2017 6:12 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		11.00	13.00	14.00	16.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	31,902				11.00
13.00	01300	NURSING ADMINISTRATION	2,126	72,939			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	581	0	147,916		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,145	0	450	80,867	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,663	13,625	4,558	3,839	30.00
40.00	04000	SUBPROVIDER - IPF	3,314	9,684	1,143	2,297	40.00
43.00	04300	NURSERY	960	2,804	1,013	385	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,306	6,739	12,711	5,872	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	243	709	256	725	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,999	5,841	8,387	21,776	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	2,367	6,918	49,263	15,643	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,025	2,996	1,856	1,736	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,787	5,829	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	772	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	111	68.00
69.00	06900	ELECTROCARDIOLOGY	320	936	0	1,530	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	36,031	1,480	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	7,943	365	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,229	3,592	0	8,414	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	561	1,640	120	430	75.01
76.97	07697	CARDIAC REHABILITATION	65	189	117	190	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,991	0	12,531	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,586	7,558	2,471	6,571	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,543	7,431	3,316	2,902	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,024	70,662	143,953	80,867	0118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	463	1,352	179	0	192.00
193.00	19300	NONPAID WORKERS	98	0	129	0	193.00
194.00	07950	EMERALD POINT	317	925	3,655	0	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0200.00
201.00		Negative Cost Centers	0	0	0	0	0201.00
202.00		TOTAL (sum lines 118-201)	31,902	72,939	147,916	80,867	0202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/19/2017 6:12 pm
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
16.00	01600				16.00
19.00	01900				19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	337,728	0	337,728	30.00
40.00	04000	163,730	0	163,730	40.00
43.00	04300	25,521	0	25,521	43.00
44.00	04400	0	0	0	44.00
45.00	04500	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	253,528	0	253,528	50.00
52.00	05200	28,590	0	28,590	52.00
53.00	05300	0	0	0	53.00
54.00	05400	207,367	0	207,367	54.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	177,716	0	177,716	60.00
60.01	06001	0	0	0	60.01
65.00	06500	53,577	0	53,577	65.00
66.00	06600	129,301	0	129,301	66.00
67.00	06700	34,168	0	34,168	67.00
68.00	06800	16,624	0	16,624	68.00
69.00	06900	8,714	0	8,714	69.00
71.00	07100	47,513	0	47,513	71.00
72.00	07200	10,516	0	10,516	72.00
73.00	07300	89,614	0	89,614	73.00
75.00	07500	0	0	0	75.00
75.01	07501	54,137	0	54,137	75.01
76.97	07697	12,559	0	12,559	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	543,533	0	543,533	88.00
90.00	09000	0	0	0	90.00
91.00	09100	99,915	0	99,915	91.00
92.00	09200	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	85,277	0	85,277	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	0	0	0	113.00
118.00		2,379,628	0	2,379,628	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
192.00	19200	109,180	0	109,180	192.00
193.00	19300	14,151	0	14,151	193.00
194.00	07950	210,725	0	210,725	194.00
194.01	07951	0	0	0	194.01
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		2,713,684	0	2,713,684	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0137

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

Worksheet B-1

Date/Time Prepared:
5/19/2017 6:12 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	136,785				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		136,785			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	282	282	10,729,051		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	34,290	34,290	1,477,424	-4,891,089	5.00
6.00 00600	MAINTENANCE & REPAIRS	11,113	11,113	281,224	0	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,938	1,938	0	0	8.00
9.00 00900	HOUSEKEEPING	1,798	1,798	367,339	0	9.00
10.00 01000	DIETARY	3,383	3,383	392,219	0	10.00
11.00 01100	CAFETERIA	942	942	268,436	0	11.00
13.00 01300	NURSING ADMINISTRATION	2,026	2,026	424,275	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	6,262	6,262	120,121	0	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,891	2,891	234,300	0	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	9,583	9,583	1,081,135	0	30.00
40.00 04000	SUBPROVIDER - IPF	4,486	4,486	696,951	0	40.00
43.00 04300	NURSERY	239	239	266,782	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	8,399	8,399	635,356	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,012	1,012	67,437	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,851	5,851	564,721	0	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	2,538	2,538	583,132	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	1,582	1,582	243,098	0	65.00
66.00 06600	PHYSICAL THERAPY	4,437	4,437	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,234	1,234	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	592	592	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	128	128	79,152	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,643	1,643	460,829	0	73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01 07501	SNR DAY TREATMENT- WHITE OAKS	2,018	2,018	132,403	0	75.01
76.97 07697	CARDIAC REHABILITATION	396	396	14,542	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	18,797	18,797	873,751	0	88.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	2,284	2,284	640,845	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	2,065	2,065	575,661	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	132,209	132,209	10,481,133	-4,891,089	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	190.00
192.00 19200	PHYSICIANS PRIVATE OFFICES	4,022	4,022	159,352	0	192.00
193.00 19300	NONPAID WORKERS	554	554	28,559	0	193.00
194.00 07950	EMERALD POINT	0	0	60,007	0	194.00
194.01 07951	CONVENIENT CARE PRE-RHC	0	0	0	0	194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,351,661	1,208,299	2,404,651		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	9.881646	8.833564	0.224125		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			5,278		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000492		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0137

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

Worksheet B-1

Date/Time Prepared:
5/19/2017 6:12 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
		6.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	91,100					6.00
8.00	00800	1,938	133,840				8.00
9.00	00900	1,798	309	87,364			9.00
10.00	01000	3,383	5,454	3,383	35,428		10.00
11.00	01100	942	1,027	942	0	337,207	11.00
13.00	01300	2,026	0	2,026	0	22,472	13.00
14.00	01400	6,262	459	6,262	0	6,143	14.00
16.00	01600	2,891	0	2,891	0	12,107	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	9,583	37,491	9,583	14,471	49,285	30.00
40.00	04000	4,486	22,100	4,486	5,097	35,028	40.00
43.00	04300	239	6,090	239	0	10,143	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	8,399	16,626	8,399	0	24,377	50.00
52.00	05200	1,012	1,540	1,012	0	2,564	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	5,851	6,123	5,851	0	21,126	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	2,538	5,437	2,538	0	25,024	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	1,582	3,332	1,582	0	10,837	65.00
66.00	06600	4,437	0	4,437	0	0	66.00
67.00	06700	1,234	0	1,234	0	0	67.00
68.00	06800	592	0	592	0	0	68.00
69.00	06900	128	0	128	0	3,384	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	1,643	0	1,643	0	12,993	73.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	2,018	0	2,018	0	5,931	75.01
76.97	07697	396	7,434	396	0	684	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	18,797	1,169	18,797	0	31,616	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	2,284	14,390	2,284	0	27,337	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	2,065	3,499	2,065	0	26,879	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		86,524	132,480	82,788	19,568	327,930	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	4,022	877	4,022	0	4,891	192.00
193.00	19300	554	0	554	0	1,040	193.00
194.00	07950	0	483	0	15,860	3,346	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		1,851,836	196,348	696,981	531,343	490,699	202.00
203.00		20.327508	1.467035	7.977897	14.997827	1.455186	203.00
204.00		250,631	45,205	54,033	86,564	31,902	204.00
205.00		2.751164	0.337754	0.618481	2.443378	0.094607	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0137

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

Worksheet B-1

Date/Time Prepared:
5/19/2017 6:12 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		13.00	14.00	16.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
6.00	00600					6.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	263,829				13.00
14.00	01400	0	1,478,157			14.00
16.00	01600	0	4,496	61,132,092		16.00
19.00	01900	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	49,285	45,551	2,901,572	0	30.00
40.00	04000	35,028	11,422	1,736,433	0	40.00
43.00	04300	10,143	10,120	290,847	0	43.00
44.00	04400	0	0	0	0	44.00
45.00	04500	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	24,377	127,026	4,438,649	0	50.00
52.00	05200	2,564	2,558	548,083	0	52.00
53.00	05300	0	0	0	100	53.00
54.00	05400	21,126	83,815	16,467,576	0	54.00
57.00	05700	0	0	0	0	57.00
58.00	05800	0	0	0	0	58.00
59.00	05900	0	0	0	0	59.00
60.00	06000	25,024	492,300	11,823,569	0	60.00
60.01	06001	0	0	0	0	60.01
65.00	06500	10,837	18,546	1,311,878	0	65.00
66.00	06600	0	17,857	4,405,983	0	66.00
67.00	06700	0	0	583,877	0	67.00
68.00	06800	0	0	83,676	0	68.00
69.00	06900	3,384	0	1,156,457	0	69.00
71.00	07100	0	360,065	1,118,724	0	71.00
72.00	07200	0	79,378	275,589	0	72.00
73.00	07300	12,993	0	6,359,775	0	73.00
75.00	07500	0	0	0	0	75.00
75.01	07501	5,931	1,195	325,008	0	75.01
76.97	07697	684	1,173	143,640	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	0	125,220	0	0	88.00
90.00	09000	0	0	0	0	90.00
91.00	09100	27,337	24,691	4,967,012	0	91.00
92.00	09200					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	26,879	33,139	2,193,744	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
118.00		255,592	1,438,552	61,132,092	100	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
192.00	19200	4,891	1,790	0	0	192.00
193.00	19300	0	1,292	0	0	193.00
194.00	07950	3,346	36,523	0	0	194.00
194.01	07951	0	0	0	0	194.01
200.00						200.00
201.00						201.00
202.00		1,216,522	571,271	768,041	0	202.00
203.00		4.611025	0.386475	0.012564	0.000000	203.00
204.00		72,939	147,916	80,867	0	204.00
205.00		0.276463	0.100068	0.001323	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0137

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

Worksheet C
Part I
Date/Time Prepared:
5/19/2017 6:12 pm

		Title XVIII		Hospital		PPS
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		3,111,358	0	3,111,358	30.00
40.00	04000 SUBPROVIDER - IPF		1,692,441	34,956	1,727,397	40.00
43.00	04300 NURSERY		646,392	0	646,392	43.00
44.00	04400 SKILLED NURSING FACILITY		0	0	0	44.00
45.00	04500 NURSING FACILITY		0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		2,016,899	0	2,016,899	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		217,873	0	217,873	52.00
53.00	05300 ANESTHESIOLOGY		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,188,586	0	2,188,586	54.00
57.00	05700 CT SCAN		0	0	0	57.00
58.00	05800 MRI		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		2,545,900	0	2,545,900	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	565,124	0	565,124	65.00
66.00	06600 PHYSICAL THERAPY	0	1,219,960	0	1,219,960	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	309,847	0	309,847	67.00
68.00	06800 SPEECH PATHOLOGY	0	167,608	0	167,608	68.00
69.00	06900 ELECTROCARDIOLOGY		172,070	0	172,070	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		588,906	0	588,906	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		130,329	0	130,329	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,941,833	0	1,941,833	73.00
75.00	07500 ASC (NON-DISTINCT PART)		0	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS		391,851	9,561	401,412	75.01
76.97	07697 CARDIAC REHABILITATION		60,547	0	60,547	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		5,509,964	0	5,509,964	88.00
90.00	09000 CLINIC		0	0	0	90.00
91.00	09100 EMERGENCY		1,417,388	0	1,417,388	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		266,804	0	266,804	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		1,226,002	0	1,226,002	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	0	26,387,682	44,517	26,432,199	200.00
201.00	Less Observation Beds		266,804		266,804	201.00
202.00	Total (see instructions)	0	26,120,878	44,517	26,165,395	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0137

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

Worksheet C
Part I
Date/Time Prepared:
5/19/2017 6:12 pm

		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,767,396		2,767,396		30.00
40.00	04000	SUBPROVIDER - I/PF	1,656,136		1,656,136		40.00
43.00	04300	NURSERY	277,397		277,397		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	331,813	4,106,836	4,438,649	0.454395	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	382,636	165,447	548,083	0.397518	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	672,221	15,795,355	16,467,576	0.132903	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,926,004	9,897,565	11,823,569	0.215324	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	303,405	1,008,473	1,311,878	0.430775	65.00
66.00	06600	PHYSICAL THERAPY	246,176	4,159,807	4,405,983	0.276887	66.00
67.00	06700	OCCUPATIONAL THERAPY	187,739	396,138	583,877	0.530672	67.00
68.00	06800	SPEECH PATHOLOGY	36,746	46,930	83,676	2.003059	68.00
69.00	06900	ELECTROCARDIOLOGY	90,153	1,066,304	1,156,457	0.148791	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	352,516	766,208	1,118,724	0.526409	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,829	273,760	275,589	0.472911	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,425,116	4,934,660	6,359,776	0.305330	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	325,008	325,008	1.205666	75.01
76.97	07697	CARDIAC REHABILITATION	0	143,640	143,640	0.421519	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,726,473	2,726,473		88.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	468,451	4,498,561	4,967,012	0.285360	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	37,397	190,526	227,923	1.170588	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	221,859	1,971,885	2,193,744	0.558863	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	11,384,990	52,473,576	63,858,566		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	11,384,990	52,473,576	63,858,566		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/19/2017 6:12 pm
Cost Center Description			PPS Inpatient Ratio 11.00	Title XVIII	Hospital PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.454395		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.397518		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.132903		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.215324		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.430775		65.00
66.00	06600	PHYSICAL THERAPY	0.276887		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.530672		67.00
68.00	06800	SPEECH PATHOLOGY	2.003059		68.00
69.00	06900	ELECTROCARDIOLOGY	0.148791		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.526409		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.472911		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305330		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	1.235083		75.01
76.97	07697	CARDIAC REHABILITATION	0.421519		76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.285360		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	1.170588		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.558863		95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part I Date/Time Prepared: 5/19/2017 6:12 pm
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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		
Title XVIII Hospital PPS								
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	337,728	18,165	319,563	2,571	124.30	30.00	
40.00	SUBPROVIDER - IPF	163,730	0	163,730	1,699	96.37	40.00	
43.00	NURSERY	25,521		25,521	357	71.49	43.00	
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00	
45.00	NURSING FACILITY	0		0	0	0.00	45.00	
200.00	Total (Lines 30-199)	526,979		508,814	4,627		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	775	96,333					30.00
40.00	SUBPROVIDER - IPF	1,319	127,112					40.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
45.00	NURSING FACILITY	0	0					45.00
200.00	Total (Lines 30-199)	2,094	223,445					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 5/19/2017 6:12 pm
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Cost Center Description		Title XVIII			Hospital	PPS	
		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	253,528	4,438,649	0.057118	54,899	3,136	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	28,590	548,083	0.052164	1,551	81	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	207,367	16,467,576	0.012592	474,183	5,971	54.00
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
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	177,716	11,823,569	0.015031	773,295	11,623	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	53,577	1,311,878	0.040840	171,024	6,985	65.00
66.00	06600 PHYSICAL THERAPY	129,301	4,405,983	0.029347	37,369	1,097	66.00
67.00	06700 OCCUPATIONAL THERAPY	34,168	583,877	0.058519	16,214	949	67.00
68.00	06800 SPEECH PATHOLOGY	16,624	83,676	0.198671	10,712	2,128	68.00
69.00	06900 ELECTROCARDIOLOGY	8,714	1,156,457	0.007535	58,456	440	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	47,513	1,118,724	0.042471	125,039	5,311	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10,516	275,589	0.038158	1,554	59	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	89,614	6,359,776	0.014091	429,231	6,048	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	54,137	325,008	0.166571	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	12,559	143,640	0.087434	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	543,533	2,726,473	0.199354	0	0	88.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	99,915	4,967,012	0.020116	363,170	7,306	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	28,961	227,923	0.127065	26,830	3,409	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,796,333	56,963,893		2,543,527	54,543	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0137		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part III Date/Time Prepared: 5/19/2017 6:12 pm	
Title XVIII			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
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
200.00		Total (lines 30-199)	0	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	2,571	0.00	775	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	1,699	0.00	1,319	0	0	40.00
43.00	04300	NURSERY	357	0.00	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0.00	0	0	0	45.00
200.00		Total (lines 30-199)	4,627		2,094	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/19/2017 6:12 pm
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Cost Center Description		Title XVIII				Hospital	PPS
		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	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (Lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/19/2017 6:12 pm
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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)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,438,649	0.000000	0.000000	54,899	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	548,083	0.000000	0.000000	1,551	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,467,576	0.000000	0.000000	474,183	54.00
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
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	11,823,569	0.000000	0.000000	773,295	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	1,311,878	0.000000	0.000000	171,024	65.00
66.00	06600	PHYSICAL THERAPY	0	4,405,983	0.000000	0.000000	37,369	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	583,877	0.000000	0.000000	16,214	67.00
68.00	06800	SPEECH PATHOLOGY	0	83,676	0.000000	0.000000	10,712	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,156,457	0.000000	0.000000	58,456	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,118,724	0.000000	0.000000	125,039	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	275,589	0.000000	0.000000	1,554	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,359,776	0.000000	0.000000	429,231	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	325,008	0.000000	0.000000	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	143,640	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	2,726,473	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	4,967,012	0.000000	0.000000	363,170	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	227,923	0.000000	0.000000	26,830	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	56,963,893			2,543,527	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/19/2017 6:12 pm
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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	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	1,559,555	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2,142	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	5,413,885	0	54.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MRI	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	1,485,201	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	391,181	0	65.00
66.00	06600 PHYSICAL THERAPY	0	5,592	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,481	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,541	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	465,464	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	212,753	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	145,314	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,681,611	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	0	263,630	0	75.01
76.97	07697 CARDIAC REHABILITATION	0	82,935	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	1,282,699	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0	129,769	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	13,124,753	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/19/2017 6:12 pm
Title XVIII		Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.454395	1,559,555	0	0	708,654	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.397518	2,142	0	0	851	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.132903	5,413,885	0	0	719,522	54.00
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
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.215324	1,485,201	0	0	319,799	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.430775	391,181	0	0	168,511	65.00
66.00	06600	PHYSICAL THERAPY	0.276887	5,592	0	0	1,548	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.530672	1,481	0	0	786	67.00
68.00	06800	SPEECH PATHOLOGY	2.003059	1,541	0	0	3,087	68.00
69.00	06900	ELECTROCARDIOLOGY	0.148791	465,464	0	0	69,257	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.526409	212,753	0	0	111,995	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.472911	145,314	0	0	68,721	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305330	1,681,611	0	35,536	513,446	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	1.205666	263,630	0	0	317,850	75.01
76.97	07697	CARDIAC REHABILITATION	0.421519	82,935	0	0	34,959	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.285360	1,282,699	0	0	366,031	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	1.170588	129,769	0	0	151,906	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.558863	0	0	0	0	95.00
200.00		Subtotal (see instructions)		13,124,753	0	35,536	3,556,923	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		13,124,753	0	35,536	3,556,923	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/19/2017 6:12 pm
Title XVIII		Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	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
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
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 PAT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	10,850	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	0	10,850	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	10,850	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0137 Component CCN: 14-S137	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 5/19/2017 6:12 pm
Title XVIII			Subprovider - IPF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	253,528	4,438,649	0.057118	4,496	257	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	28,590	548,083	0.052164	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	207,367	16,467,576	0.012592	87,799	1,106	54.00
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
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	177,716	11,823,569	0.015031	241,636	3,632	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	53,577	1,311,878	0.040840	14,557	595	65.00
66.00	06600 PHYSICAL THERAPY	129,301	4,405,983	0.029347	29,315	860	66.00
67.00	06700 OCCUPATIONAL THERAPY	34,168	583,877	0.058519	5,774	338	67.00
68.00	06800 SPEECH PATHOLOGY	16,624	83,676	0.198671	6,942	1,379	68.00
69.00	06900 ELECTROCARDIOLOGY	8,714	1,156,457	0.007535	31,472	237	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	47,513	1,118,724	0.042471	8,201	348	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10,516	275,589	0.038158	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	89,614	6,359,776	0.014091	306,441	4,318	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	54,137	325,008	0.166571	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	12,559	143,640	0.087434	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	543,533	2,726,473	0.199354	0	0	88.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	99,915	4,967,012	0.020116	76,982	1,549	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0	227,923	0.000000	2,965	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,767,372	56,963,893		816,580	14,619	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0137 Component CCN: 14-S137	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/19/2017 6:12 pm
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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
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
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 PAT	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
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0137 Component CCN: 14-S137	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/19/2017 6:12 pm
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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	4,438,649	0.000000	0.000000	4,496	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	548,083	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	16,467,576	0.000000	0.000000	87,799	54.00
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
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	11,823,569	0.000000	0.000000	241,636	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	1,311,878	0.000000	0.000000	14,557	65.00
66.00	06600 PHYSICAL THERAPY	0	4,405,983	0.000000	0.000000	29,315	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	583,877	0.000000	0.000000	5,774	67.00
68.00	06800 SPEECH PATHOLOGY	0	83,676	0.000000	0.000000	6,942	68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,156,457	0.000000	0.000000	31,472	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	1,118,724	0.000000	0.000000	8,201	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	275,589	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6,359,776	0.000000	0.000000	306,441	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	0	325,008	0.000000	0.000000	0	75.01
76.97	07697 CARDIAC REHABILITATION	0	143,640	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	2,726,473	0.000000	0.000000	0	88.00
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	4,967,012	0.000000	0.000000	76,982	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0	227,923	0.000000	0.000000	2,965	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	56,963,893			816,580	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0137 Component CCN: 14-S137	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/19/2017 6:12 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MRI	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
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 PAT	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
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	0	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/19/2017 6:12 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,405	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,571	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,338	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		675	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		159	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)		775	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)		675	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		212.56	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		150.15	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)		3,111,358	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)		143,478	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)		23,874	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)		167,352	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,944,006	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,944,006	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,145.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		887,437	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)		887,437	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/19/2017 6:12 pm
Title XVIII			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)	0	0	0.00	0	0
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)					710,526
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,597,963
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					96,333
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					54,543
52.00 Total Program excludable cost (sum of lines 50 and 51)					150,876
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,447,087
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
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
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
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)					143,478
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					143,478
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
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
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					233
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,145.08
89.00 Observation bed cost (line 87 x line 88) (see instructions)					266,804

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0137		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/19/2017 6:12 pm	
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	337,728	3,111,358	0.108547	266,804	28,961	90.00
91.00	Nursing School cost	0	3,111,358	0.000000	266,804	0	91.00
92.00	Allied health cost	0	3,111,358	0.000000	266,804	0	92.00
93.00	All other Medical Education	0	3,111,358	0.000000	266,804	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0137 Component CCN: 14-S137	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/19/2017 6:12 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,699	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,699	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,699	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,319	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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,727,397	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,727,397	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,727,397	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,016.71	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,341,040	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,341,040	41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1
					Component CCN: 14-S137		Date/Time Prepared: 5/19/2017 6:12 pm
					Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	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)					225,104	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,566,144	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)					127,112	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					14,619	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					141,731	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,424,413	53.00	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0	54.00	
55.00 Target amount per discharge					0.00	55.00	
56.00 Target amount (line 54 x line 55)					0	56.00	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00	
58.00 Bonus payment (see instructions)					0	58.00	
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00	
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00	
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00	
62.00 Relief payment (see instructions)					0	62.00	
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00	
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00	
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00	
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00	
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00	
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00 Program routine service cost (line 9 x line 71)						72.00	
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00 Program capital-related costs (line 9 x line 76)						77.00	
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00 Inpatient routine service cost per diem limitation						81.00	
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00 Reasonable inpatient routine service costs (see instructions)						83.00	
84.00 Program inpatient ancillary services (see instructions)						84.00	
85.00 Utilization review - physician compensation (see instructions)						85.00	
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0	87.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0137 Component CCN: 14-S137		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/19/2017 6:12 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	163,730	1,727,397	0.094784	0	0	90.00
91.00	Nursing School cost	0	1,727,397	0.000000	0	0	91.00
92.00	Allied health cost	0	1,727,397	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,727,397	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/19/2017 6:12 pm	
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		739,992		30.00
40.00	04000 SUBPROVIDER - I/PF		0		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.454395	54,899	24,946	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.397518	1,551	617	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.132903	474,183	63,020	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.215324	773,295	166,509	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.430775	171,024	73,673	65.00
66.00	06600 PHYSICAL THERAPY	0.276887	37,369	10,347	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.530672	16,214	8,604	67.00
68.00	06800 SPEECH PATHOLOGY	2.003059	10,712	21,457	68.00
69.00	06900 ELECTROCARDIOLOGY	0.148791	58,456	8,698	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.526409	125,039	65,822	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.472911	1,554	735	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.305330	429,231	131,057	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	1.235083	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	0.421519	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.285360	363,170	103,634	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.170588	26,830	31,407	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		2,543,527	710,526	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		2,543,527		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0137 Component CCN: 14-S137	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/19/2017 6:12 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
40.00	04000 SUBPROVIDER - IPF		1,287,712	40.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.454395	4,496	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.397518	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.132903	87,799	54.00
57.00	05700 CT SCAN	0.000000	0	57.00
58.00	05800 MRI	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000 LABORATORY	0.215324	241,636	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.430775	14,557	65.00
66.00	06600 PHYSICAL THERAPY	0.276887	29,315	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.530672	5,774	67.00
68.00	06800 SPEECH PATHOLOGY	2.003059	6,942	68.00
69.00	06900 ELECTROCARDIOLOGY	0.148791	31,472	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.526409	8,201	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.472911	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.305330	306,441	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	1.235083	0	75.01
76.97	07697 CARDIAC REHABILITATION	0.421519	0	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000 CLINIC	0.000000	0	90.00
91.00	09100 EMERGENCY	0.285360	76,982	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	1.170588	2,965	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (sum of lines 50-94 and 96-98)		816,580	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)		816,580	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0137 Component CCN: 14-U137	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/19/2017 6:12 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
40.00	04000 SUBPROVIDER - I/PF		0		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.454395	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.397518	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.132903	20,279	2,695	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.215324	110,236	23,736	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.430775	43,528	18,751	65.00
66.00	06600 PHYSICAL THERAPY	0.276887	134,090	37,128	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.530672	135,488	71,900	67.00
68.00	06800 SPEECH PATHOLOGY	2.003059	14,468	28,980	68.00
69.00	06900 ELECTROCARDIOLOGY	0.148791	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.526409	34,499	18,161	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.472911	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.305330	199,639	60,956	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	1.205666	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	0.421519	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.285360	86	25	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.170588	169	198	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		692,482	262,530	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		692,482		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/19/2017 6:12 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1,546,837	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		0	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		29.08	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.09	30.00
31.00	Percentage of Medicaid patient days (see instructions)		48.69	31.00
32.00	Sum of lines 30 and 31		52.78	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00
34.00	Disproportionate share adjustment (see instructions)		46,405	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/19/2017 6:12 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000033872	0.000029291	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	216,990	175,086	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	162,446	44,131	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	206,577		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	1,799,819		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		1,799,819	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		123,413	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		1,923,232	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		1,923,232	61.00
62.00	Deductibles billed to program beneficiaries		271,740	62.00
63.00	Coinurance billed to program beneficiaries		966	63.00
64.00	Allowable bad debts (see instructions)		87,800	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		57,070	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		87,800	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		1,707,596	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		4,743	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/19/2017 6:12 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2016	311,963	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2017	103,987	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		5,574	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		2,122,715	71.00
71.01	Sequestration adjustment (see instructions)		42,454	71.01
72.00	Interim payments		2,208,414	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		-128,153	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0137		Period: From 01/01/2016 To 12/31/2016		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/19/2017 6:12 pm	
		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,546,837	0	0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	46,405	46,405	0	46,405	11.00
11.01	Uncompensated care payments	36.00	206,577	162,446	44,131	206,577	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,799,819	1,755,688	44,131	1,799,819	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	1,799,819	1,755,688	44,131	1,799,819	15.00
16.00	Payment for inpatient program capital	50.00	123,413	92,391	31,022	123,413	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			1,848,079	75,153	1,923,232	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/19/2017 6:12 pm
		Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	123,413	92,391	31,022	123,413	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	123,413	92,391	31,022	123,413	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	311,963	311,963		311,963	28.00
29.00	Low volume adjustment on or after October 1	70.97	103,987		103,987	103,987	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	4,743	3,551	1,192	4,743	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	1,803	1,803	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/19/2017 6:12 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		10,850	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,556,923	2.00
3.00	PPS payments		2,370,362	3.00
4.00	Outlier payment (see instructions)		1,410	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)		10,850	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		35,536	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)		35,536	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 charge basis 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)		35,536	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		24,686	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)		10,850	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)		2,371,772	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		506,113	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,876,509	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,876,509	30.00
31.00	Primary payer payments		279	31.00
32.00	Subtotal (line 30 minus line 31)		1,876,230	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)		97,197	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		63,178	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		97,128	36.00
37.00	Subtotal (see instructions)		1,939,408	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-51	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,939,459	40.00
40.01	Sequestration adjustment (see instructions)		38,789	40.01
41.00	Interim payments		1,907,858	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-7,188	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: 14-0137

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

Worksheet E-1
Part I
Date/Time Prepared:
5/19/2017 6:12 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,018,389		1,898,578	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	09/27/2016	26,400	12/12/2016	9,280	3.01	
3.02		12/12/2016	7,020		0	3.02	
3.03		12/13/2016	156,605		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)		190,025		9,280	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,208,414		1,907,858	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		128,153		7,188	6.02	
7.00	Total Medicare program liability (see instructions)		2,080,261		1,900,670	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: 14-0137 Component CCN: 14-S137	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part I Date/Time Prepared: 5/19/2017 6:12 pm	
		Title XVIII	Subprovider - IPF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				0
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		1,243,940		0
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)				0
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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)		1,243,940		0
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)				0
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				0
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		1		0
7.00	Total Medicare program liability (see instructions)		1,243,939		0
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				0

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0137
Component CCN: 14-U137

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

Worksheet E-1
Part I
Date/Time Prepared:
5/19/2017 6:12 pm

Title XVIII

Swing Beds - SNF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		239,644		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)		239,644		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		239,644		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: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/19/2017 6:12 pm
		Title XVIII	Hospital	PPS
				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		1,007	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		775	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		65	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		2,338	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		63,858,566	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		568,554	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: 14-0137 Component CCN: 14-U137	Period: From 01/01/2016 To 12/31/2016	Worksheet E-2 Date/Time Prepared: 5/19/2017 6:12 pm
		Title XVIII	Swing Beds - SNF	PPS
		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)	261,923	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)			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	675	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)	261,923	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	261,923	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)	261,923	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	17,388	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)	244,535	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)	244,535	0	19.00
19.01	Sequestration adjustment (see instructions)	4,891	0	19.01
20.00	Interim payments	239,644	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)	0	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: 14-0137 Component CCN: 14-S137	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part II Date/Time Prepared: 5/19/2017 6:12 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,192,986 1.00
2.00	Net IPF PPS Outlier Payments			211,524 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			4.642077 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,404,510 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,404,510 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,404,510 18.00
19.00	Deductibles			135,184 19.00
20.00	Subtotal (line 18 minus line 19)			1,269,326 20.00
21.00	Coinsurance			0 21.00
22.00	Subtotal (line 20 minus line 21)			1,269,326 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,269,326 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,269,326 31.00
31.01	Sequestration adjustment (see instructions)			25,387 31.01
32.00	Interim payments			1,243,940 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			-1 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			211,524 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 14-0137

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

Worksheet G

Date/Time Prepared:
5/19/2017 6:12 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	907,430	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	13,283,943	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,530,675	0	0	0	6.00
7.00	Inventory	537,232	0	0	0	7.00
8.00	Prepaid expenses	271,849	0	0	0	8.00
9.00	Other current assets	630,115	0	0	0	9.00
10.00	Due from other funds	226,324	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,326,218	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,540,441	0	0	0	12.00
13.00	Land improvements	400,000	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	6,194,481	0	0	0	15.00
16.00	Accumulated depreciation	-445,001	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	1,734,104	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	112,404	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	9,536,429	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	1,511,067	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,511,067	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	17,373,714	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,267,532	0	0	0	37.00
38.00	Salaries, wages, and fees payable	921,219	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	671,504	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	5,522,493	0	0	0	43.00
44.00	Other current liabilities	1,252,714	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,635,462	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,349,687	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,726,228	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	8,075,915	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,711,377	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-337,663	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-337,663	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	17,373,714	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0137

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

Worksheet G-1

Date/Time Prepared:
5/19/2017 6:12 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		3,951,525		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-4,289,188				2.00
3.00	Total (sum of line 1 and line 2)		-337,663		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)		-337,663		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-337,663		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0137

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/19/2017 6:12 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,709,949		2,709,949	1.00
2.00	SUBPROVIDER - IPF	1,656,136		1,656,136	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	303,923		303,923	5.00
6.00	Swing bed - NF	39,070		39,070	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,709,078		4,709,078	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)	4,709,078		4,709,078	17.00
18.00	Ancillary services	5,984,433	43,818,255	49,802,688	18.00
19.00	Outpatient services	505,848	4,723,448	5,229,296	19.00
20.00	RURAL HEALTH CLINIC	0	2,726,473	2,726,473	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	221,859	1,974,798	2,196,657	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	312,929	1,789,028	2,101,957	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,734,147	55,032,002	66,766,149	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,368,707		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)		31,368,707		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0137

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

Worksheet G-3

Date/Time Prepared:
5/19/2017 6:12 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	66,766,149	1.00
2.00	Less contractual allowances and discounts on patients' accounts	41,190,600	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,575,549	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,368,707	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,793,158	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	12,846	6.00
7.00	Income from investments	34,056	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	139,808	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	515	16.00
17.00	Revenue from sale of drugs to other than patients	163,486	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	1,558	21.00
22.00	Rental of hospital space	398,620	22.00
23.00	Governmental appropriations	25,480	23.00
24.00	MISC REVENUE	290,588	24.00
24.01	GAIN/LOSS DISPOSAL FIXED ASSET	45,309	24.01
24.02	AUXILIARY	391,704	24.02
25.00	Total other income (sum of lines 6-24)	1,503,970	25.00
26.00	Total (line 5 plus line 25)	-4,289,188	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-4,289,188	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0137	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/19/2017 6:12 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		123,413	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		6.66	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		123,413	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 14-0137 Component CCN: 14-3491		Period: From 01/01/2016 To 12/31/2016		Worksheet M-1 Date/Time Prepared: 5/19/2017 6:12 pm	
		RHC I		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	285,639	352,104	637,743	0	637,743	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	226,263	290,326	516,589	0	516,589	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	172,257	246,471	418,728	0	418,728	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)	684,159	888,901	1,573,060	0	1,573,060	10.00
11.00	Physician Services Under Agreement	0	424,418	424,418	0	424,418	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	424,418	424,418	0	424,418	14.00
15.00	Medical Supplies	0	110,529	110,529	0	110,529	15.00
16.00	Transportation (Health Care Staff)	0	10,288	10,288	0	10,288	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	338,894	338,894	0	338,894	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	459,711	459,711	0	459,711	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	684,159	1,773,030	2,457,189	0	2,457,189	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	7,259	7,259	0	7,259	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	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	7,259	7,259	0	7,259	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	2,540	2,540	0	2,540	29.00
30.00	Administrative Costs	189,592	810,083	999,675	226,053	1,225,728	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	189,592	812,623	1,002,215	226,053	1,228,268	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	873,751	2,592,912	3,466,663	226,053	3,692,716	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0137

Period: From 01/01/2016

Worksheet M-1

Component CCN: 14-3491

To 12/31/2016

Date/Time Prepared: 5/19/2017 6:12 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	637,743		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	516,589		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	418,728		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	1,573,060		10.00
11.00	Physician Services Under Agreement	-211,665	212,753		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)	-211,665	212,753		14.00
15.00	Medical Supplies	0	110,529		15.00
16.00	Transportation (Health Care Staff)	0	10,288		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	338,894		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	459,711		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-211,665	2,245,524		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	7,259		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	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	7,259		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	2,540		29.00
30.00	Administrative Costs	-40	1,225,688		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-40	1,228,228		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-211,705	3,481,011		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0137 Component CCN: 14-3491	Period: From 01/01/2016 To 12/31/2016	Worksheet M-2 Date/Time Prepared: 5/19/2017 6:12 pm
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		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	2.20	7,764	4,200	9,240	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	4.11	11,083	2,100	8,631	3.00
4.00	Subtotal (sum of lines 1 through 3)	6.31	18,847		17,871	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)	6.31	18,847		18,847	8.00
9.00	Physician Services Under Agreements		1,070		1,070	9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES			
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)		2,245,524
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		7,259
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)		2,252,783
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)		0.996778
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)		1,228,228
15.00	Parent provider overhead allocated to facility (see instructions)		2,028,953
16.00	Total overhead (sum of lines 14 and 15)		3,257,181
17.00	Allowable GME overhead (see instructions)		0
18.00	Enter the amount from line 16		3,257,181
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)		3,246,686
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)		5,492,210

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0137 Component CCN: 14-3491	Period: From 01/01/2016 To 12/31/2016	Worksheet M-3 Date/Time Prepared: 5/19/2017 6:12 pm	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			5,492,210	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			31,438	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			5,460,772	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			18,847	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			1,070	5.00
6.00	Total adjusted visits (line 4 plus line 5)			19,917	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			274.18	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)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		274.18	274.18	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	5,570	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	1,527,183	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	1,527,183	16.00
16.01	Total program charges (see instructions)(from contractor's records)			815,812	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			2,186	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			4,093	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			1,135,086	16.04
16.05	Total program cost (see instructions)		0	1,139,179	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			104,233	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			142,316	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			1,139,179	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			31,438	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,170,617	22.00
23.00	Allowable bad debts (see instructions)			32,474	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			21,108	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			32,474	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
26.00	Net reimbursable amount (see instructions)			1,191,725	26.00
26.01	Sequestration adjustment (see instructions)			23,835	26.01
27.00	Interim payments			836,520	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)			331,370	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0137 Component CCN: 14-3491	Period: From 01/01/2016 To 12/31/2016	Worksheet M-4 Date/Time Prepared: 5/19/2017 6:12 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,573,060	1,573,060	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000858	0.001317	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,350	2,072	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		7,331	2,101	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		8,681	4,173	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,245,524	2,245,524	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		3,246,686	3,246,686	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.003866	0.001858	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		12,552	6,032	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		21,233	10,205	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		88	135	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		241.28	75.59	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		88	135	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		21,233	10,205	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			31,438	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			31,438	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0137 Component CCN: 14-3491	Period: From 01/01/2016 To 12/31/2016	Worksheet M-5 Date/Time Prepared: 5/19/2017 6:12 pm
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		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		836,520	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)		836,520	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		331,370	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,167,890	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00