

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: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/31/2017 10:59 am
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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: 5/31/2017 Time: 10:59 am

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 CROSSROADS COMMUNITY HOSPITAL (14-0294) 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	-113,665	-26,736	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		31,424		0	10.00
10.01 RURAL HEALTH CLINIC II	0		43,185		0	10.01
200.00 Total	0	-113,665	47,873	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-MEDI-CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0294			Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 10:58 am				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 8 DOCTORS PARK ROAD			PO Box:						1.00	
2.00	City: MT VERNON			State: IL		Zip Code: 62864		County: JEFFERSON		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		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		CROSSROADS COMMUNITY HOSPITAL	140294	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		CROSSROADS COMMUNITY HOSPITAL	14U294	99914		04/12/1989	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		CROSSROADS FAMILY MED OF MT. VERNON	148524	99914		07/19/2013	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II		CROSSROADS FAMILY MED OF WAYNE CITY	148523	99914		07/19/2013	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FOHC										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)						4			21.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						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	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.			333	0	0	0	49	0	24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0294		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 10:58 am				
		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.					2	26.00			
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2	27.00			
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0	35.00			
		Beginning:		Ending:						
		1.00		2.00						
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.						36.00			
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					1	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)						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.			01/01/2016		12/31/2016	38.00			
		Y/N		Y/N						
		1.00		2.00						
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00		
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00		
		V		XVII		XIX				
		1.00		2.00		3.00				
Prospective Payment System (PPS)-Capital										
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00	
Teaching Hospitals										
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.								58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)					N			60.00	
		Y/N		IME		Direct GME				
		1.00		2.00		3.00		4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N						0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)			0.00		0.00				61.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0294

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

Worksheet S-2
Part I
Date/Time Prepared:
5/31/2017 10:58 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0294		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 10:58 am	
	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.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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				1.00	
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a critical access hospital (CAH)?		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)				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.				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:	19,311	162,301		0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 10:58 am	
		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	
DO NOT USE THIS LINE					
119.00	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	Y	119.00	
120.00	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.			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	HB0776	140.00	
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: QUORUM GROUP CORPORATION	Contractor's Name: WISCONSIN PHYSICIAN SERVICES		Contractor's Number: 52280	
142.00	Street: 1573 MALLORY LANE	PO Box: SUITE 100			
143.00	City: BRENTWOOD	State: TN		Zip Code: 37027	
		1.00	2.00	3.00	
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.	Y		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	2.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N	149.00	
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - I/PF	N	N	N	N
157.00	Subprovider - I/RP	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0294		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 10:58 am		
							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)						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: 14-0294		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part II Date/Time Prepared: 5/31/2017 10:58 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		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)	N					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.	N					4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/01/2017	Y	03/01/2017		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/31/2017 10:58 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		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			Y	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?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
			1.00	2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PHA' LESA		PATTON	41.00
42.00	Enter the employer/company name of the cost report preparer.	OHC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615.221.3601		PHALESA_PATTON@QUORUMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0294

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

Worksheet S-2
Part II
Date/Time Prepared:
5/31/2017 10:58 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0294

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

Worksheet S-3
Part I
Date/Time Prepared:
5/31/2017 10:58 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	40	14,640	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)		40	14,640	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	7	2,562	0.00	0	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)		47	17,202	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		47				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0294

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

Worksheet S-3
Part I
Date/Time Prepared:
5/31/2017 10:58 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,488	340	2,380			1.00
2.00 HMO and other (see instructions)	154	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,488	340	2,380			7.00
8.00 INTENSIVE CARE UNIT	142	42	215			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	1,630	382	2,595	0.00	169.13	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	1,944	0	6,211	0.00	4.92	26.00
26.01 RURAL HEALTH CLINIC II	1,061	0	3,271	0.00	3.20	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	177.25	27.00
28.00 Observation Bed Days		0	698			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0294

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

Worksheet S-3
Part I
Date/Time Prepared:
5/31/2017 10:58 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	469	161	866	1.00
2.00	HMO and other (see instructions)			49	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	469	161	866	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0294

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

Worksheet S-3
Part II
Date/Time Prepared:
5/31/2017 10:58 am

	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	9,798,385	0	9,798,385	368,690.00	26.58
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		326,253	0	326,253	6,328.00	51.56
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		247,468	0	247,468	10,559.00	23.44
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)		58,135	59,418	117,553	7,687.00	15.29
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		601,648	0	601,648	10,959.00	54.90
12.00	Contract labor: Top level management and other management and administrative services		195,166	0	195,166	2,344.50	83.24
13.00	Contract Labor: Physician-Part A - Administrative		12,000	0	12,000	100.00	120.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		1,096,440	0	1,096,440	32,748.00	33.48
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)		2,783,040	0	2,783,040		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		54,929	0	54,929		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		69,782	0	69,782		
24.00	Wage-related costs (RHC/FQHC)		83,861	0	83,861		
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	141,122	0	141,122	5,499.00	25.66
27.00	Administrative & General	5.00	1,504,648	-59,418	1,445,230	65,617.00	22.03

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0294

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

Worksheet S-3
Part II
Date/Time Prepared:
5/31/2017 10:58 am

		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.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	152,077	0	152,077	6,256.00	24.31	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		442,295	0	442,295	30,587.46	14.46	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		342,385	0	342,385	20,700.42	16.54	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	657,830	0	657,830	17,014.00	38.66	38.00
39.00	Central Services and Supply	14.00	167,718	0	167,718	9,199.00	18.23	39.00
40.00	Pharmacy	15.00	414,245	0	414,245	6,490.00	63.83	40.00
41.00	Medical Records & Medical Records Library	16.00	326,135	0	326,135	17,606.00	18.52	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0294

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

Worksheet S-3
Part III
Date/Time Prepared:
5/31/2017 10:58 am

	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 III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	10,009,344	0	10,009,344	403,090.88	24.83	1.00
2.00	Excluded area salaries (see instructions)	58,135	59,418	117,553	7,687.00	15.29	2.00
3.00	Subtotal salaries (line 1 minus line 2)	9,951,209	-59,418	9,891,791	395,403.88	25.02	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,905,254	0	1,905,254	46,151.50	41.28	4.00
5.00	Subtotal wage-related costs (see inst.)	2,783,040	0	2,783,040	0.00	28.13	5.00
6.00	Total (sum of lines 3 thru 5)	14,639,503	-59,418	14,580,085	441,555.38	33.02	6.00
7.00	Total overhead cost (see instructions)	4,148,455	-59,418	4,089,037	178,968.88	22.85	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part IV Date/Time Prepared: 5/31/2017 10:58 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		160,196	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		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		1,764,027	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		18,225	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		10,033	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		78	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		6,780	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		199,708	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		567,174	17.00
18.00	Medicare Taxes - Employers Portion Only		132,646	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		84,467	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		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		2,943,334	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE COST		48,280	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part V Date/Time Prepared: 5/31/2017 10:58 am
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	601,648	2,943,334	1.00
2.00	Hospital	601,648	2,943,334	2.00
3.00	Subprovider - IPF			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			8.00
9.00	Hospital-Based NF			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
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0294 Component CCN: 14-8524		Period: From 01/01/2016 To 12/31/2016		Worksheet S-8 Date/Time Prepared: 5/31/2017 10:58 am	
		RHC I		Cost			
				1.00			
1.00	Clinic Address and Identification Street	3050 BROADWAY				1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00	City, State, ZIP Code, County	MT. VERNON		IL 62864		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 Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
				1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0		10.00	
		Sunday		Monday		Tuesday	
		from to		from to		from	
		1.00 2.00		3.00 4.00		5.00	
11.00	Facility hours of operations (1) Clinic	08:00		16:30		08:00	
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		0		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.					13.00	
		Provider name		CCN number			
		1.00		2.00			
14.00	RHC/FQHC name, CCN number	Y/N		V		Total Visits	
		1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
		County		4.00			
2.00	City, State, ZIP Code, County	JEFFERSON				2.00	
		Tuesday		Wednesday		Thursday	
		to		from to		from to	
		6.00		7.00 8.00		9.00 10.00	
11.00	Facility hours of operations (1) Clinic	16:30		08:00		16:30	
		08:00		16:30		08:00	
		16:30		08:00		16:30	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0294
Component CCN: 14-8524

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

Worksheet S-8
Date/Time Prepared:
5/31/2017 10:58 am

		RHC I		Cost		
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
11.00	Facility hours of operations (1) Clinic	08:00	16:30			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0294 Component CCN: 14-8523		Period: From 01/01/2016 To 12/31/2016		Worksheet S-8 Date/Time Prepared: 5/31/2017 10:58 am	
		RHC II		Cost			
				1.00			
1.00	1.00	Clinic Address and Identification Street		1209 W ROBINSON		1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00	2.00	City, State, ZIP Code, County		WAYNE CITY IL 62864		2.00	
				1.00			
3.00	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	4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS Act)				4.00	
5.00	5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00	
6.00	6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00	
7.00	7.00	Appalachian Regional Commission				7.00	
8.00	8.00	Look-Alikes				8.00	
9.00	9.00	OTHER (SPECIFY)				9.00	
				1.00		2.00	
10.00	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	
				Sunday		Monday	
				Tuesday			
				from		to	
				1.00		2.00	
				3.00		4.00	
				5.00			
11.00	11.00	Facility hours of operations (1) Clinic		08:00 16:30		08:00	
				1.00		2.00	
12.00	12.00	Have you received an approval for an exception to the productivity standard?		N		0	
13.00	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.					
				Provider name		CCN number	
				1.00		2.00	
14.00	14.00	RHC/FQHC name, CCN number					
				Y/N		V	
				1.00		2.00	
				XVIII		XIX	
				3.00		4.00	
						Total Visits	
				5.00			
15.00	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)					
				County			
				4.00			
2.00	2.00	City, State, ZIP Code, County		WAYNE			
				Tuesday		Wednesday	
				Thursday			
				to		from	
				6.00		7.00	
				8.00		9.00	
				10.00			
11.00	11.00	Facility hours of operations (1) Clinic		16:30 08:00 16:30 08:00		12:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0294 Component CCN: 14-8523		Period: From 01/01/2016 To 12/31/2016		Worksheet S-8 Date/Time Prepared: 5/31/2017 10:58 am	
				RHC II		Cost	
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) Clinic	08:00	16:30				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet S-10 Date/Time Prepared: 5/31/2017 10:58 am
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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)		0.149348	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		2,197,044	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		2,043,259	5.00	
6.00	Medicaid charges		51,398,714	6.00	
7.00	Medicaid cost (line 1 times line 6)		7,676,295	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		3,435,992	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		347	9.00	
10.00	Stand-alone CHIP charges		21,347	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		3,188	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		2,841	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		3,438,833	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)		497,520	112,069	609,589
21.00	Cost of patients approved for charity care (line 1 times line 20)		74,304	16,737	91,041
22.00	Partial payment by patients approved for charity care		0	0	0
23.00	Cost of charity care (line 21 minus line 22)		74,304	16,737	91,041
			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)		1,240,392		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		187,699		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		1,052,693		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		157,218		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		248,259		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,687,092		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0294

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

Worksheet A
Date/Time Prepared:
5/31/2017 10:58 am

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		768,311	768,311	348,448	1,116,759	1.00
2.00	00200		1,970,273	1,970,273	947,135	2,917,408	2.00
4.00	00400		31,361	172,483	2,189,111	2,361,594	4.00
5.00	00500	1,504,648	8,850,849	10,355,497	-2,821,466	7,534,031	5.00
7.00	00700	152,077	1,264,050	1,416,127	-55,736	1,360,391	7.00
8.00	00800	0	89,369	89,369	-171	89,198	8.00
9.00	00900	0	549,610	549,610	0	549,610	9.00
10.00	01000	0	659,245	659,245	-258,283	400,962	10.00
11.00	01100	0	0	0	257,454	257,454	11.00
13.00	01300	657,830	286,289	944,119	-13,443	930,676	13.00
14.00	01400	167,718	1,874,852	2,042,570	-1,579,222	463,348	14.00
15.00	01500	414,245	740,713	1,154,958	-704,090	450,868	15.00
16.00	01600	326,135	140,249	466,384	-5,333	461,051	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	789,351	950,923	1,740,274	-6,856	1,733,418	30.00
31.00	03100	199,693	62,195	261,888	-4,246	257,642	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	869,438	3,290,308	4,159,746	-732,892	3,426,854	50.00
51.00	05100	496,358	60,828	557,186	-557,186	0	51.00
53.00	05300	0	657,552	657,552	0	657,552	53.00
54.00	05400	494,470	593,296	1,087,766	-112,740	975,026	54.00
54.01	03630	97,327	94,897	192,224	0	192,224	54.01
56.00	05600	39,484	267,547	307,031	0	307,031	56.00
57.00	05700	137,133	205,224	342,357	0	342,357	57.00
58.00	05800	9,555	171,423	180,978	0	180,978	58.00
60.00	06000	670,571	550,433	1,221,004	-43,050	1,177,954	60.00
62.00	06200	293	55,025	55,318	-35,164	20,154	62.00
65.00	06500	256,597	57,136	313,733	-1,338	312,395	65.00
66.00	06600	349,351	236,235	585,586	-114,966	470,620	66.00
67.00	06700	167,800	18,480	186,280	0	186,280	67.00
68.00	06800	67,108	8,822	75,930	0	75,930	68.00
69.00	06900	233,754	34,213	267,967	0	267,967	69.00
71.00	07100	0	0	0	222,919	222,919	71.00
72.00	07200	0	0	0	2,249,155	2,249,155	72.00
73.00	07300	0	0	0	657,544	657,544	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03610	98,713	32,548	131,261	-1,908	129,353	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	388,181	100,476	488,657	0	488,657	88.00
88.01	08801	185,540	129,291	314,831	0	314,831	88.01
91.00	09100	825,758	1,551,981	2,377,739	-3,159	2,374,580	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		9,740,250	26,354,004	36,094,254	-179,483	35,914,771	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	22,650	-153,568	-130,918	0	-130,918	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	179,483	179,483	194.01
194.02	07954	35,485	21,482	56,967	0	56,967	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07952	0	0	0	0	0	194.04
200.00		9,798,385	26,221,918	36,020,303	0	36,020,303	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0294

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

Worksheet A
Date/Time Prepared:
5/31/2017 10:58 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	62,872	1,179,631	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-197,183	2,720,225	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,589	2,358,005	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,652,749	5,881,282	5.00
7.00	00700	OPERATION OF PLANT	-12,080	1,348,311	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	89,198	8.00
9.00	00900	HOUSEKEEPING	0	549,610	9.00
10.00	01000	DIETARY	0	400,962	10.00
11.00	01100	CAFETERIA	-97,037	160,417	11.00
13.00	01300	NURSING ADMINISTRATION	0	930,676	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	463,348	14.00
15.00	01500	PHARMACY	0	450,868	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-176	460,875	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-484,704	1,248,714	30.00
31.00	03100	INTENSIVE CARE UNIT	0	257,642	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-89,200	3,337,654	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	-642,884	14,668	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-74,273	900,753	54.00
54.01	03630	ULTRA SOUND	-3,836	188,388	54.01
56.00	05600	RADIOISOTOPE	-532	306,499	56.00
57.00	05700	CT SCAN	-30,072	312,285	57.00
58.00	05800	MRI	-84	180,894	58.00
60.00	06000	LABORATORY	0	1,177,954	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	20,154	62.00
65.00	06500	RESPIRATORY THERAPY	0	312,395	65.00
66.00	06600	PHYSICAL THERAPY	0	470,620	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	186,280	67.00
68.00	06800	SPEECH PATHOLOGY	0	75,930	68.00
69.00	06900	ELECTROCARDIOLOGY	0	267,967	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	222,919	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,249,155	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	657,544	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	76.00
76.01	03610	SLEEP LAB	0	129,353	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	488,657	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	314,831	88.01
91.00	09100	EMERGENCY	-1,083,120	1,291,460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,308,647	31,606,124	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-130,918	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	MARKETING	0	179,483	194.01
194.02	07954	SENIOR CIRCLE	-616	56,351	194.02
194.03	07953	VACANT SPACE	0	0	194.03
194.04	07952	GUEST MEALS	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	-4,309,263	31,711,040	200.00

RECLASSIFICATIONS

Provider CCN: 14-0294

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

Worksheet A-6

Date/Time Prepared:
5/31/2017 10:58 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,191,219	1.00
2.00		0.00	0	0	2.00
	0		0	2,191,219	
B - OXYGEN SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	55,736	1.00
	0		0	55,736	
C - RENTAL AND LEASE RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	943,943	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	0		0	943,943	
D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	45,316	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	303,132	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,192	3.00
	0		0	351,640	
E - MARKETING					
1.00	MARKETING	194.01	59,418	120,065	1.00
	0		59,418	120,065	
F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	167,183	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,249,155	2.00
	0		0	2,416,338	
G - COST OF DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	657,544	1.00
	0		0	657,544	
H - BLOOD AND LAB					
1.00	LABORATORY	60.00	0	45,465	1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	10,301	0	2.00
	0		10,301	45,465	
I - MISCELLANEOUS DEPARTMENTS					
1.00	OPERATING ROOM	50.00	496,358	60,828	1.00
	0		496,358	60,828	
J - DIETARY					
1.00	CAFETERIA	11.00	0	257,454	1.00
	0		0	257,454	
500.00	Grand Total: Increases		566,077	7,100,232	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - EMPLOYEE BENEFITS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,162,456	0		1.00
2.00	OPERATING ROOM	50.00	0	28,763	0		2.00
	0		0	2,191,219			
B - OXYGEN SUPPLY							
1.00	OPERATION OF PLANT	7.00	0	55,736	0		1.00
	0		0	55,736			
C - RENTAL AND LEASE RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,108	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	127,887	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	171	0		3.00
4.00	DIETARY	10.00	0	829	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	13,443	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,888	0		6.00
7.00	PHARMACY	15.00	0	46,546	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	5,333	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	6,856	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	4,246	0		10.00
11.00	OPERATING ROOM	50.00	0	422,311	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	112,740	0		12.00
13.00	LABORATORY	60.00	0	78,214	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	1,338	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	114,966	0		15.00
16.00	SLEEP LAB	76.01	0	1,908	0		16.00
17.00	EMERGENCY	91.00	0	3,159	0		17.00
	0		0	943,943			
D - OTHER CAPITAL COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	351,640	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	351,640			
E - MARKETING							
1.00	ADMINISTRATIVE & GENERAL	5.00	59,418	120,065	0		1.00
	0		59,418	120,065			
F - MEDICAL SUPPLIES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,577,334	0		1.00
2.00	OPERATING ROOM	50.00	0	839,004	0		2.00
	0		0	2,416,338			
G - COST OF DRUGS							
1.00	PHARMACY	15.00	0	657,544	0		1.00
	0		0	657,544			
H - BLOOD AND LAB							
1.00	LABORATORY	60.00	10,301	0	0		1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	45,465	0		2.00
	0		10,301	45,465			
I - MISCELLANEOUS DEPARTMENTS							
1.00	RECOVERY ROOM	51.00	496,358	60,828	0		1.00
	0		496,358	60,828			
J - DIETARY							
1.00	DIETARY	10.00	0	257,454	0		1.00
	0		0	257,454			
500.00	Grand Total: Decreases		566,077	7,100,232			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0294

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

Worksheet A-7
Part I
Date/Time Prepared:
5/31/2017 10:58 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	961,157	0	0	0	1.00
2.00	Land Improvements	411,367	0	0	0	2.00
3.00	Buildings and Fixtures	28,744,448	120,633	0	120,633	3.00
4.00	Building Improvements	5,753,603	70,813	0	70,813	4.00
5.00	Fixed Equipment	2,193,183	42,962	0	42,962	5.00
6.00	Movable Equipment	13,152,819	0	0	0	6.00
7.00	HIT designated Assets	4,787,565	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	56,004,142	234,408	0	234,408	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	56,004,142	234,408	0	234,408	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	961,157	0			1.00
2.00	Land Improvements	411,367	0			2.00
3.00	Buildings and Fixtures	28,865,081	0			3.00
4.00	Building Improvements	5,824,416	0			4.00
5.00	Fixed Equipment	2,236,145	0			5.00
6.00	Movable Equipment	12,705,943	0			6.00
7.00	HIT designated Assets	4,787,565	0			7.00
8.00	Subtotal (sum of lines 1-7)	55,791,674	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	55,791,674	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0294

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

Worksheet A-7
Part II
Date/Time Prepared:
5/31/2017 10:58 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	768,311	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,935,074	35,199	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,703,385	35,199	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	768,311				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,970,273				2.00
3.00	Total (sum of lines 1-2)	0	2,738,584				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0294

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

Worksheet A-7
Part III
Date/Time Prepared:
5/31/2017 10:58 am

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	36,062,021	0	36,062,021	0.646369	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	19,729,653	0	19,729,653	0.353631	0	2.00
3.00	Total (sum of lines 1-2)	55,791,674	0	55,791,674	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	892,806	-140,565	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,705,225	979,142	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,598,031	838,577	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	0	45,316	303,132	78,942	1,179,631	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	32,666	3,192	0	0	2,720,225	2.00
3.00	Total (sum of lines 1-2)	32,666	48,508	303,132	78,942	3,899,856	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0294

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

Worksheet A-8

Date/Time Prepared:
5/31/2017 10:58 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-74,114		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-60		CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,408,705				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	349,271				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-97,037		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			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-176		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	124,495		CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-224,731		CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 ADMIN & GENERAL ORGANIZATION COST	A	-184,463		ADMINISTRATIVE & GENERAL	5.00	0	33.00

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	
33.01	MARKETING EXPENSE	A	-57,478	ADMINISTRATIVE & GENERAL	5.00	0 33.01
33.02	MARKETING EXPENSE	A	-616	SENIOR CIRCLE	194.02	0 33.02
33.03	COUNTRY CLUB DUES	A	-680	ADMINISTRATIVE & GENERAL	5.00	0 33.03
33.04	PHYSICIAN RECRUITING	A	-194,005	ADMINISTRATIVE & GENERAL	5.00	0 33.04
33.05	LOBBYING EXPENSE	A	-24,242	ADMINISTRATIVE & GENERAL	5.00	0 33.05
33.06	CHARITABLE EXPENSE	A	-5,050	ADMINISTRATIVE & GENERAL	5.00	0 33.06
33.07	SPECIAL EVENTS	A	-30,107	ADMINISTRATIVE & GENERAL	5.00	0 33.07
33.08	MEDICAL STAFF RELATIONS	A	-7,751	ADMINISTRATIVE & GENERAL	5.00	0 33.08
33.09	ILLINOIS PROVIDER TAX	A	-1,295,100	ADMINISTRATIVE & GENERAL	5.00	0 33.09
33.10	GIFT SHOP EXPENSE	A	-2,134	ADMINISTRATIVE & GENERAL	5.00	0 33.10
33.11	NON-ALLOWABLE LEGAL FEES	A	-86,363	ADMINISTRATIVE & GENERAL	5.00	0 33.11
33.12	OTHER NON-ALLOWABLE EXPENSES	A	-27,799	ADMINISTRATIVE & GENERAL	5.00	0 33.12
33.13	TELEPHONE BENEFIT COSTS	A	-3,589	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.13
33.14	TELEPHONE DEPRECIATION COST	A	-5,058	CAP REL COSTS-MVBLE EQUIP	2.00	9 33.14
33.15	TELEVISION EXPENSE	A	-12,080	OPERATION OF PLANT	7.00	0 33.15
33.17	FITNESS REVENUE	B	-920	ADMINISTRATIVE & GENERAL	5.00	0 33.17
33.19			0		0.00	0 33.19
33.20			0		0.00	0 33.20
33.21	RENTAL INCOME	B	-140,565	CAP REL COSTS-BLDG & FIXT	1.00	10 33.21
33.22	OTHER MISCELLANEOUS REVENUE	B	99,794	ADMINISTRATIVE & GENERAL	5.00	0 33.22
33.23			0		0.00	0 33.23
33.24			0		0.00	0 33.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,309,263			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: 14-0294
 Period: From 01/01/2016 To 12/31/2016
 Worksheet A-8-1
 Date/Time Prepared: 5/31/2017 10:58 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOCATION - CAPITAL	49,110	0
2.00	5.00	ADMINISTRATIVE & GENERAL	DIRECT ALLOCATION - OPERATI	20,042	0
3.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	89,138	0
4.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	5,994	0
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	941	0
4.02	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	23,838	0
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	31,725	0
4.04	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	744,394	0
4.05	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	181,612	243,515
4.06	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	-161,251
4.07	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	662,585
4.08	5.00	ADMINISTRATIVE & GENERAL	401K FEES	0	2,352
4.10	5.00	ADMINISTRATIVE & GENERAL	CORPORATE OVERHEAD ALLOCATIO	0	181,720
4.11	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICES ALLOCATION	35,515	0
4.12	5.00	ADMINISTRATIVE & GENERAL	QHC SPECIFIC COST ALLOCATION	230,925	0
4.15	5.00	ADMINISTRATIVE & GENERAL	PPSI FEES	0	6,583
4.18	5.00	ADMINISTRATIVE & GENERAL	PASI COLLECTION FEES	0	102,747
4.20	5.00	ADMINISTRATIVE & GENERAL	PASI LIEN UNIT COLLECTION FE	0	25,712
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,413,234	1,063,963

* 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	0.00	CHSPSC	100.00	6.00
7.00	B	0.00	PASI	100.00	7.00
8.00	B	0.00	QHR	100.00	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: 14-0294

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

Worksheet A-8-1

Date/Time Prepared:
5/31/2017 10:58 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	49,110	14		1.00
2.00	20,042	0		2.00
3.00	89,138	0		3.00
4.00	5,994	14		4.00
4.01	941	11		4.01
4.02	23,838	14		4.02
4.03	31,725	11		4.03
4.04	744,394	0		4.04
4.05	-61,903	0		4.05
4.06	161,251	0		4.06
4.07	-662,585	0		4.07
4.08	-2,352	0		4.08
4.10	-181,720	0		4.10
4.11	35,515	0		4.11
4.12	230,925	0		4.12
4.15	-6,583	0		4.15
4.18	-102,747	0		4.18
4.20	-25,712	0		4.20
5.00	349,271			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	CHAIN OPERATOR		6.00
7.00	COLLECTION SERV		7.00
8.00	HOSPITAL MGMT		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: 14-0294

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

Worksheet A-8-2

Date/Time Prepared:
5/31/2017 10:58 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	484,704	484,704	0	0	0	1.00
2.00	50.00	OPERATING ROOM	89,200	89,200	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	642,884	642,884	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	74,273	74,273	0	0	0	4.00
5.00	54.01	ULTRA SOUND	3,836	3,836	0	0	0	5.00
6.00	56.00	RADIOISOTOPE	532	532	0	0	0	6.00
7.00	57.00	CT SCAN	30,072	30,072	0	0	0	7.00
8.00	58.00	MRI	84	84	0	0	0	8.00
9.00	60.00	LABORATORY	12,000	0	12,000	260,300	100	9.00
10.00	91.00	EMERGENCY	1,083,120	1,083,120	0	0	0	10.00
200.00			2,420,705	2,408,705	12,000		100	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	54.01	ULTRA SOUND	0	0	0	0	0	5.00
6.00	56.00	RADIOISOTOPE	0	0	0	0	0	6.00
7.00	57.00	CT SCAN	0	0	0	0	0	7.00
8.00	58.00	MRI	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	12,514	626	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			12,514	626	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	484,704	1.00
2.00	50.00	OPERATING ROOM	0	0	0	89,200	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	642,884	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	74,273	4.00
5.00	54.01	ULTRA SOUND	0	0	0	3,836	5.00
6.00	56.00	RADIOISOTOPE	0	0	0	532	6.00
7.00	57.00	CT SCAN	0	0	0	30,072	7.00
8.00	58.00	MRI	0	0	0	84	8.00
9.00	60.00	LABORATORY	0	12,514	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	1,083,120	10.00
200.00			0	12,514	0	2,408,705	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0294

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

Worksheet B
Part I
Date/Time Prepared:
5/31/2017 10:58 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,179,631	1,179,631			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	2,720,225		2,720,225		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,358,005	7,541	17,390	2,382,936	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,881,282	125,999	290,553	356,607	5.00
7.00 00700	OPERATION OF PLANT	1,348,311	230,582	531,721	37,525	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	89,198	5,171	11,925	0	8.00
9.00 00900	HOUSEKEEPING	549,610	38,877	89,650	0	9.00
10.00 01000	DIETARY	400,962	36,329	83,774	0	10.00
11.00 01100	CAFETERIA	160,417	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	930,676	12,028	27,738	162,320	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	463,348	25,687	59,234	41,385	14.00
15.00 01500	PHARMACY	450,868	9,537	21,991	102,215	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	460,875	23,364	53,877	80,474	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,248,714	212,952	491,067	194,773	30.00
31.00 03100	INTENSIVE CARE UNIT	257,642	44,994	103,757	49,274	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,337,654	144,679	333,628	337,012	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
53.00 05300	ANESTHESIOLOGY	14,668	1,602	3,694	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	900,753	40,704	93,863	122,011	54.00
54.01 03630	ULTRA SOUND	188,388	4,768	10,996	24,016	54.01
56.00 05600	RADIOISOTOPE	306,499	4,000	9,224	9,743	56.00
57.00 05700	CT SCAN	312,285	0	0	33,838	57.00
58.00 05800	MRI	180,894	0	0	2,358	58.00
60.00 06000	LABORATORY	1,177,954	27,982	64,527	162,922	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	20,154	1,424	3,284	2,614	62.00
65.00 06500	RESPIRATORY THERAPY	312,395	12,797	29,509	63,316	65.00
66.00 06600	PHYSICAL THERAPY	470,620	5,162	11,903	86,203	66.00
67.00 06700	OCCUPATIONAL THERAPY	186,280	0	0	41,405	67.00
68.00 06800	SPEECH PATHOLOGY	75,930	0	0	16,559	68.00
69.00 06900	ELECTROCARDIOLOGY	267,967	0	0	57,679	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	222,919	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	2,249,155	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	657,544	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03020	ACUPUNCTURE	0	0	0	0	76.00
76.01 03610	SLEEP LAB	129,353	0	0	24,358	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	488,657	0	0	95,784	88.00
88.01 08801	RURAL HEALTH CLINIC II	314,831	0	0	45,782	88.01
91.00 09100	EMERGENCY	1,291,460	58,849	135,707	203,757	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	31,606,124	1,075,028	2,479,012	2,353,930	31,231,302
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,607	8,317	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	-130,918	3,504	8,079	5,589	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07951	MARKETING	179,483	1,920	4,429	14,661	194.01
194.02 07954	SENIOR CIRCLE	56,351	5,059	11,665	8,756	194.02
194.03 07953	VACANT SPACE	0	90,513	208,723	0	194.03
194.04 07952	GUEST MEALS	0	0	0	0	194.04
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	31,711,040	1,179,631	2,720,225	2,382,936	31,711,040

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0294

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

Worksheet B
Part I
Date/Time Prepared:
5/31/2017 10:58 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,654,441				5.00
7.00	00700	OPERATION OF PLANT	567,916	2,716,055			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,102	17,222	151,618		8.00
9.00	00900	HOUSEKEEPING	179,283	129,480	4,186	991,086	9.00
10.00	01000	DIETARY	137,757	120,994	1,337	46,671	827,824
11.00	01100	CAFETERIA	42,410	0	0	0	233,195
13.00	01300	NURSING ADMINISTRATION	299,475	40,061	0	15,453	0
14.00	01400	CENTRAL SERVICES & SUPPLY	155,890	85,550	0	33,000	0
15.00	01500	PHARMACY	154,557	31,762	0	12,252	0
16.00	01600	MEDICAL RECORDS & LIBRARY	163,540	77,813	0	30,015	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	567,749	709,239	48,212	273,577	532,429
31.00	03100	INTENSIVE CARE UNIT	120,467	149,854	8,765	57,804	48,108
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,097,955	481,853	29,219	185,867	0
51.00	05100	RECOVERY ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	5,278	5,335	0	2,058	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	305,971	135,564	8,765	52,292	0
54.01	03630	ULTRA SOUND	60,322	15,881	0	6,126	0
56.00	05600	RADIOISOTOPE	87,103	13,322	0	5,139	0
57.00	05700	CT SCAN	91,507	0	0	0	0
58.00	05800	MRI	48,447	0	0	0	0
60.00	06000	LABORATORY	378,953	93,194	0	35,948	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,264	4,742	0	1,829	0
65.00	06500	RESPIRATORY THERAPY	110,514	42,619	4,383	16,440	0
66.00	06600	PHYSICAL THERAPY	151,722	17,191	0	6,631	0
67.00	06700	OCCUPATIONAL THERAPY	60,194	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	24,452	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	86,093	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	58,934	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	594,623	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	173,839	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03020	ACUPUNCTURE	0	0	0	0	0
76.01	03610	SLEEP LAB	40,637	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	154,512	0	0	0	0
88.01	08801	RURAL HEALTH CLINIC II	95,337	0	0	0	0
91.00	09100	EMERGENCY	446,735	195,999	46,751	75,603	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,497,538	2,367,675	151,618	856,705	813,732
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,152	12,012	0	4,633	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,669	0	4,501	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	MARKETING	53,006	6,396	0	2,467	0
194.02	07954	SENIOR CIRCLE	21,634	16,848	0	6,499	0
194.03	07953	VACANT SPACE	79,111	301,455	0	116,281	0
194.04	07952	GUEST MEALS	0	0	0	0	14,092
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	6,654,441	2,716,055	151,618	991,086	827,824

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0294

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	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	436,022					11.00
13.00	01300	27,487	1,515,238				13.00
14.00	01400	14,852	0	878,946			14.00
15.00	01500	10,484	111,434	1,265	906,365		15.00
16.00	01600	28,427	0	1,382	0	919,767	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	51,008	212,339	16,379	0	25,800	30.00
31.00	03100	11,156	53,718	2,868	0	3,302	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	76,209	367,411	253,057	0	168,439	50.00
51.00	05100	0	0	0	0	0	51.00
53.00	05300	0	0	3,255	0	81,942	53.00
54.00	05400	31,552	133,015	6,111	0	39,224	54.00
54.01	03630	5,981	26,181	1,045	0	13,699	54.01
56.00	05600	2,655	10,621	795	0	11,149	56.00
57.00	05700	9,745	36,889	7,799	0	142,727	57.00
58.00	05800	571	2,570	142	0	16,376	58.00
60.00	06000	48,387	177,616	37,631	0	147,750	60.00
62.00	06200	773	2,850	0	0	2,371	62.00
65.00	06500	16,163	69,026	5,495	0	10,383	65.00
66.00	06600	18,112	0	1,818	0	17,914	66.00
67.00	06700	7,527	0	546	0	10,954	67.00
68.00	06800	2,151	0	200	0	1,137	68.00
69.00	06900	15,860	62,881	220	0	21,180	69.00
71.00	07100	0	0	45,758	0	4,442	71.00
72.00	07200	0	0	461,680	0	62,507	72.00
73.00	07300	0	0	0	906,365	33,329	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03610	6,250	26,554	3,539	0	5,783	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	3,726	0	4,434	88.00
88.01	08801	0	0	4,756	0	2,536	88.01
91.00	09100	45,497	222,133	14,329	0	92,389	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		430,847	1,515,238	873,796	906,365	919,767	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	1,974	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	3,394	0	1,943	0	0	194.01
194.02	07954	1,781	0	1,233	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07952	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		436,022	1,515,238	878,946	906,365	919,767	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0294

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

Worksheet B
Part I
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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
7.00	00700				7.00
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
15.00	01500				15.00
16.00	01600				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	4,584,238	0	4,584,238	30.00
31.00	03100	911,709	0	911,709	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	6,812,983	0	6,812,983	50.00
51.00	05100	0	0	0	51.00
53.00	05300	117,832	0	117,832	53.00
54.00	05400	1,869,825	0	1,869,825	54.00
54.01	03630	357,403	0	357,403	54.01
56.00	05600	460,250	0	460,250	56.00
57.00	05700	634,790	0	634,790	57.00
58.00	05800	251,358	0	251,358	58.00
60.00	06000	2,352,864	0	2,352,864	60.00
62.00	06200	47,305	0	47,305	62.00
65.00	06500	693,040	0	693,040	65.00
66.00	06600	787,276	0	787,276	66.00
67.00	06700	306,906	0	306,906	67.00
68.00	06800	120,429	0	120,429	68.00
69.00	06900	511,880	0	511,880	69.00
71.00	07100	332,053	0	332,053	71.00
72.00	07200	3,367,965	0	3,367,965	72.00
73.00	07300	1,771,077	0	1,771,077	73.00
74.00	07400	0	0	0	74.00
76.00	03020	0	0	0	76.00
76.01	03610	236,474	0	236,474	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	747,113	0	747,113	88.00
88.01	08801	463,242	0	463,242	88.01
91.00	09100	2,829,209	0	2,829,209	91.00
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
118.00		30,567,221	0	30,567,221	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	31,721	0	31,721	190.00
192.00	19200	-95,602	0	-95,602	192.00
194.00	07950	0	0	0	194.00
194.01	07951	267,699	0	267,699	194.01
194.02	07954	129,826	0	129,826	194.02
194.03	07953	796,083	0	796,083	194.03
194.04	07952	14,092	0	14,092	194.04
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		31,711,040	0	31,711,040	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/31/2017 10:58 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
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	7,541	17,390	24,931	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	125,999	290,553	416,552	5.00
7.00 00700	OPERATION OF PLANT	0	230,582	531,721	762,303	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	5,171	11,925	17,096	8.00
9.00 00900	HOUSEKEEPING	0	38,877	89,650	128,527	9.00
10.00 01000	DIETARY	0	36,329	83,774	120,103	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	12,028	27,738	39,766	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	25,687	59,234	84,921	14.00
15.00 01500	PHARMACY	0	9,537	21,991	31,528	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	23,364	53,877	77,241	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	212,952	491,067	704,019	30.00
31.00 03100	INTENSIVE CARE UNIT	0	44,994	103,757	148,751	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	144,679	333,628	478,307	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
53.00 05300	ANESTHESIOLOGY	0	1,602	3,694	5,296	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	40,704	93,863	134,567	54.00
54.01 03630	ULTRA SOUND	0	4,768	10,996	15,764	54.01
56.00 05600	RADIOISOTOPE	0	4,000	9,224	13,224	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
60.00 06000	LABORATORY	0	27,982	64,527	92,509	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,424	3,284	4,708	62.00
65.00 06500	RESPIRATORY THERAPY	0	12,797	29,509	42,306	65.00
66.00 06600	PHYSICAL THERAPY	0	5,162	11,903	17,065	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 PATIENT	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
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03020	ACUPUNCTURE	0	0	0	0	76.00
76.01 03610	SLEEP LAB	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01 08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
91.00 09100	EMERGENCY	0	58,849	135,707	194,556	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,075,028	2,479,012	3,554,040	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,607	8,317	11,924	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	3,504	8,079	11,583	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07951	MARKETING	0	1,920	4,429	6,349	194.01
194.02 07954	SENIOR CIRCLE	0	5,059	11,665	16,724	194.02
194.03 07953	VACANT SPACE	0	90,513	208,723	299,236	194.03
194.04 07952	GUEST MEALS	0	0	0	0	194.04
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,179,631	2,720,225	3,899,856	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/31/2017 10:58 am				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	420,279				5.00	
7.00	00700	OPERATION OF PLANT	35,867	798,563			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	1,775	5,064	23,935		8.00	
9.00	00900	HOUSEKEEPING	11,323	38,069	661	178,580	9.00	
10.00	01000	DIETARY	8,700	35,574	211	8,410	10.00	
11.00	01100	CAFETERIA	2,678	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	18,914	11,779	0	2,784	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	9,845	25,153	0	5,946	14.00	
15.00	01500	PHARMACY	9,761	9,338	0	2,208	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	10,329	22,878	0	5,408	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	35,857	208,527	7,610	49,294	30.00	
31.00	03100	INTENSIVE CARE UNIT	7,608	44,059	1,384	10,415	31.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	69,354	141,672	4,613	33,491	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	333	1,569	0	371	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,324	39,858	1,384	9,422	54.00	
54.01	03630	ULTRA SOUND	3,810	4,669	0	1,104	54.01	
56.00	05600	RADIO SOTOPE	5,501	3,917	0	926	56.00	
57.00	05700	CT SCAN	5,779	0	0	0	57.00	
58.00	05800	MRI	3,060	0	0	0	58.00	
60.00	06000	LABORATORY	23,933	27,401	0	6,477	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	459	1,394	0	330	62.00	
65.00	06500	RESPIRATORY THERAPY	6,980	12,531	692	2,962	65.00	
66.00	06600	PHYSICAL THERAPY	9,582	5,054	0	1,195	66.00	
67.00	06700	OCCUPATIONAL THERAPY	3,802	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	1,544	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	5,437	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,722	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,554	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	10,979	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00	
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00	
76.01	03610	SLEEP LAB	2,567	0	0	0	76.01	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	9,758	0	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	6,021	0	0	0	88.01	
91.00	09100	EMERGENCY	28,214	57,627	7,380	13,623	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00	
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	410,370	696,133	23,935	154,366	170,053	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	199	3,532	0	835	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,431	0	811	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	3,348	1,881	0	445	0	194.01
194.02	07954	SENIOR CIRCLE	1,366	4,954	0	1,171	0	194.02
194.03	07953	VACANT SPACE	4,996	88,632	0	20,952	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	2,945	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	420,279	798,563	23,935	178,580	172,998	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0294		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 5/31/2017 10:58 am	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	51,411					11.00
13.00	01300	NURSING ADMINISTRATION	3,241	78,183				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,751	0	128,049			14.00
15.00	01500	PHARMACY	1,236	5,750	184	61,075		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,352	0	201	0	120,251	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,014	10,956	2,386	0	3,376	30.00
31.00	03100	INTENSIVE CARE UNIT	1,315	2,772	418	0	432	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,987	18,956	36,866	0	21,946	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	474	0	10,721	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,720	6,863	890	0	5,132	54.00
54.01	03630	ULTRA SOUND	705	1,351	152	0	1,792	54.01
56.00	05600	RADIOISOTOPE	313	548	116	0	1,459	56.00
57.00	05700	CT SCAN	1,149	1,903	1,136	0	18,675	57.00
58.00	05800	MRI	67	133	21	0	2,143	58.00
60.00	06000	LABORATORY	5,705	9,165	5,482	0	19,332	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	91	147	0	0	310	62.00
65.00	06500	RESPIRATORY THERAPY	1,906	3,562	800	0	1,358	65.00
66.00	06600	PHYSICAL THERAPY	2,136	0	265	0	2,344	66.00
67.00	06700	OCCUPATIONAL THERAPY	887	0	80	0	1,433	67.00
68.00	06800	SPEECH PATHOLOGY	254	0	29	0	149	68.00
69.00	06900	ELECTROCARDIOLOGY	1,870	3,245	32	0	2,771	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	6,666	0	581	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	67,260	0	8,179	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	61,075	4,361	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	737	1,370	516	0	757	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	543	0	580	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	693	0	332	88.01
91.00	09100	EMERGENCY	5,365	11,462	2,088	0	12,088	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	50,801	78,183	127,298	61,075	120,251	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	288	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	400	0	283	0	0	194.01
194.02	07954	SENIOR CIRCLE	210	0	180	0	0	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	51,411	78,183	128,049	61,075	120,251	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/31/2017 10:58 am
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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
7.00	00700				7.00
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
15.00	01500				15.00
16.00	01600				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	1,141,343	0	1,141,343	30.00
31.00	03100	227,724	0	227,724	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	817,718	0	817,718	50.00
51.00	05100	0	0	0	51.00
53.00	05300	18,764	0	18,764	53.00
54.00	05400	222,437	0	222,437	54.00
54.01	03630	29,598	0	29,598	54.01
56.00	05600	26,106	0	26,106	56.00
57.00	05700	28,996	0	28,996	57.00
58.00	05800	5,449	0	5,449	58.00
60.00	06000	191,709	0	191,709	60.00
62.00	06200	7,466	0	7,466	62.00
65.00	06500	73,760	0	73,760	65.00
66.00	06600	38,543	0	38,543	66.00
67.00	06700	6,635	0	6,635	67.00
68.00	06800	2,149	0	2,149	68.00
69.00	06900	13,959	0	13,959	69.00
71.00	07100	10,969	0	10,969	71.00
72.00	07200	112,993	0	112,993	72.00
73.00	07300	76,415	0	76,415	73.00
74.00	07400	0	0	0	74.00
76.00	03020	0	0	0	76.00
76.01	03610	6,202	0	6,202	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	11,883	0	11,883	88.00
88.01	08801	7,525	0	7,525	88.01
91.00	09100	334,535	0	334,535	91.00
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
118.00		3,412,878	0	3,412,878	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	16,490	0	16,490	190.00
192.00	19200	16,171	0	16,171	192.00
194.00	07950	0	0	0	194.00
194.01	07951	12,859	0	12,859	194.01
194.02	07954	24,697	0	24,697	194.02
194.03	07953	413,816	0	413,816	194.03
194.04	07952	2,945	0	2,945	194.04
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		3,899,856	0	3,899,856	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0294

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

Worksheet B-1

Date/Time Prepared:
5/31/2017 10:58 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	125,922				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		125,922			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	805	805	9,657,263		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,450	13,450	1,445,230	-6,654,441	5.00
7.00	00700	OPERATION OF PLANT	24,614	24,614	152,077	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	552	552	0	0	8.00
9.00	00900	HOUSEKEEPING	4,150	4,150	0	0	9.00
10.00	01000	DIETARY	3,878	3,878	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,284	1,284	657,830	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,742	2,742	167,718	0	14.00
15.00	01500	PHARMACY	1,018	1,018	414,245	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,494	2,494	326,135	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,732	22,732	789,351	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,803	4,803	199,693	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	15,444	15,444	1,365,796	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	171	171	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,345	4,345	494,470	0	54.00
54.01	03630	ULTRA SOUND	509	509	97,327	0	54.01
56.00	05600	RADIOISOTOPE	427	427	39,484	0	56.00
57.00	05700	CT SCAN	0	0	137,133	0	57.00
58.00	05800	MRI	0	0	9,555	0	58.00
60.00	06000	LABORATORY	2,987	2,987	660,270	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	152	152	10,594	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,366	1,366	256,597	0	65.00
66.00	06600	PHYSICAL THERAPY	551	551	349,351	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	167,800	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	67,108	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	233,754	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	98,713	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	388,181	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	185,540	0	88.01
91.00	09100	EMERGENCY	6,282	6,282	825,758	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	114,756	114,756	9,539,710	-6,654,441	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	385	385	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	374	374	22,650	113,746	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	MARKETING	205	205	59,418	0	194.01
194.02	07954	SENIOR CIRCLE	540	540	35,485	0	194.02
194.03	07953	VACANT SPACE	9,662	9,662	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	194.04
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)	1,179,631	2,720,225	2,382,936	6,654,441	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.367950	21.602460	0.246751	0.264376	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			24,931	420,279	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002582	0.016697	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0294

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

Worksheet B-1

Date/Time Prepared:
5/31/2017 10:58 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	87,053				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	552	161,958			8.00
9.00	00900	HOUSEKEEPING	4,150	4,472	82,351		9.00
10.00	01000	DIETARY	3,878	1,428	3,878	34,484	10.00
11.00	01100	CAFETERIA	0	0	0	9,714	11.00
13.00	01300	NURSING ADMINISTRATION	1,284	0	1,284	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,742	0	2,742	0	14.00
15.00	01500	PHARMACY	1,018	0	1,018	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,494	0	2,494	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,732	51,499	22,732	22,179	1,518
31.00	03100	INTENSIVE CARE UNIT	4,803	9,363	4,803	2,004	332
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	15,444	31,212	15,444	0	2,268
51.00	05100	RECOVERY ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	171	0	171	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,345	9,363	4,345	0	939
54.01	03630	ULTRA SOUND	509	0	509	0	178
56.00	05600	RADIOISOTOPE	427	0	427	0	79
57.00	05700	CT SCAN	0	0	0	0	290
58.00	05800	MRI	0	0	0	0	17
60.00	06000	LABORATORY	2,987	0	2,987	0	1,440
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	152	0	152	0	23
65.00	06500	RESPIRATORY THERAPY	1,366	4,682	1,366	0	481
66.00	06600	PHYSICAL THERAPY	551	0	551	0	539
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	224
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	64
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	472
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03020	ACUPUNCTURE	0	0	0	0	0
76.01	03610	SLEEP LAB	0	0	0	0	186
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0
91.00	09100	EMERGENCY	6,282	49,939	6,282	0	1,354
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	75,887	161,958	71,185	33,897	12,822
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	385	0	385	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	374	0	374	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	MARKETING	205	0	205	0	101
194.02	07954	SENIOR CIRCLE	540	0	540	0	53
194.03	07953	VACANT SPACE	9,662	0	9,662	0	0
194.04	07952	GUEST MEALS	0	0	0	587	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	2,716,055	151,618	991,086	827,824	436,022
203.00		Unit cost multiplier (Wkst. B, Part I)	31.200016	0.936156	12.034899	24.006032	33.602189
204.00		Cost to be allocated (per Wkst. B, Part II)	798,563	23,935	178,580	172,998	51,411
205.00		Unit cost multiplier (Wkst. B, Part II)	9.173297	0.147785	2.168523	5.016761	3.962007

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0294

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

Worksheet B-1

Date/Time Prepared:
5/31/2017 10:58 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
		13.00	14.00	15.00	16.00		
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	5,632,740					13.00
14.00	01400	0	4,281,935				14.00
15.00	01500	414,245	6,165	657,544			15.00
16.00	01600	0	6,733	0	204,671,396		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	789,351	79,793	0	5,740,948		30.00
31.00	03100	199,693	13,972	0	734,750		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,365,796	1,232,814	0	37,486,607		50.00
51.00	05100	0	0	0	0		51.00
53.00	05300	0	15,857	0	18,233,616		53.00
54.00	05400	494,470	29,770	0	8,728,145		54.00
54.01	03630	97,327	5,089	0	3,048,183		54.01
56.00	05600	39,484	3,871	0	2,480,935		56.00
57.00	05700	137,133	37,996	0	31,759,420		57.00
58.00	05800	9,555	690	0	3,643,945		58.00
60.00	06000	660,270	183,324	0	32,877,111		60.00
62.00	06200	10,594	0	0	527,497		62.00
65.00	06500	256,597	26,768	0	2,310,364		65.00
66.00	06600	0	8,857	0	3,986,270		66.00
67.00	06700	0	2,659	0	2,437,443		67.00
68.00	06800	0	974	0	252,996		68.00
69.00	06900	233,754	1,073	0	4,712,916		69.00
71.00	07100	0	222,919	0	988,473		71.00
72.00	07200	0	2,249,155	0	13,909,030		72.00
73.00	07300	0	0	657,544	7,416,372		73.00
74.00	07400	0	0	0	0		74.00
76.00	03020	0	0	0	0		76.00
76.01	03610	98,713	17,243	0	1,286,894		76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	18,150	0	986,730		88.00
88.01	08801	0	23,169	0	564,367		88.01
91.00	09100	825,758	69,808	0	20,558,384		91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		5,632,740	4,256,849	657,544	204,671,396		118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0		190.00
192.00	19200	0	9,616	0	0		192.00
194.00	07950	0	0	0	0		194.00
194.01	07951	0	9,465	0	0		194.01
194.02	07954	0	6,005	0	0		194.02
194.03	07953	0	0	0	0		194.03
194.04	07952	0	0	0	0		194.04
200.00							200.00
201.00							201.00
202.00		1,515,238	878,946	906,365	919,767		202.00
203.00		0.269005	0.205268	1.378410	0.004494		203.00
204.00		78,183	128,049	61,075	120,251		204.00
205.00		0.013880	0.029904	0.092884	0.000588		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0294

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2017 10:58 am

		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		4,584,238	0	4,584,238	30.00
31.00	03100 INTENSIVE CARE UNIT		911,709	0	911,709	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		6,812,983	0	6,812,983	50.00
51.00	05100 RECOVERY ROOM		0	0	0	51.00
53.00	05300 ANESTHESIOLOGY		117,832	0	117,832	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,869,825	0	1,869,825	54.00
54.01	03630 ULTRA SOUND		357,403	0	357,403	54.01
56.00	05600 RADIOISOTOPE		460,250	0	460,250	56.00
57.00	05700 CT SCAN		634,790	0	634,790	57.00
58.00	05800 MRI		251,358	0	251,358	58.00
60.00	06000 LABORATORY		2,352,864	0	2,352,864	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		47,305	0	47,305	62.00
65.00	06500 RESPIRATORY THERAPY	0	693,040	0	693,040	65.00
66.00	06600 PHYSICAL THERAPY	0	787,276	0	787,276	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	306,906	0	306,906	67.00
68.00	06800 SPEECH PATHOLOGY	0	120,429	0	120,429	68.00
69.00	06900 ELECTROCARDIOLOGY		511,880	0	511,880	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		332,053	0	332,053	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		3,367,965	0	3,367,965	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,771,077	0	1,771,077	73.00
74.00	07400 RENAL DIALYSIS		0	0	0	74.00
76.00	03020 ACUPUNCTURE		0	0	0	76.00
76.01	03610 SLEEP LAB		236,474	0	236,474	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		747,113	0	747,113	88.00
88.01	08801 RURAL HEALTH CLINIC II		463,242	0	463,242	88.01
91.00	09100 EMERGENCY		2,829,209	0	2,829,209	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1,039,573	0	1,039,573	92.00
200.00	Subtotal (see instructions)	0	31,606,794	0	31,606,794	200.00
201.00	Less Observation Beds		1,039,573		1,039,573	201.00
202.00	Total (see instructions)	0	30,567,221	0	30,567,221	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/31/2017 10:58 am
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		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	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,673,587		4,673,587		30.00
31.00	03100	INTENSIVE CARE UNIT	734,750		734,750		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,051,265	27,435,342	37,486,607	0.181744	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	4,894,502	13,339,114	18,233,616	0.006462	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,273,224	7,454,921	8,728,145	0.214229	54.00
54.01	03630	ULTRA SOUND	249,584	2,798,599	3,048,183	0.117251	54.01
56.00	05600	RADIOISOTOPE	281,412	2,199,523	2,480,935	0.185515	56.00
57.00	05700	CT SCAN	4,319,907	27,439,513	31,759,420	0.019987	57.00
58.00	05800	MRI	103,596	3,540,349	3,643,945	0.068980	58.00
60.00	06000	LABORATORY	4,671,228	28,205,883	32,877,111	0.071565	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	322,149	205,348	527,497	0.089678	62.00
65.00	06500	RESPIRATORY THERAPY	1,513,317	797,047	2,310,364	0.299970	65.00
66.00	06600	PHYSICAL THERAPY	752,343	3,233,927	3,986,270	0.197497	66.00
67.00	06700	OCCUPATIONAL THERAPY	426,439	2,011,004	2,437,443	0.125913	67.00
68.00	06800	SPEECH PATHOLOGY	30,491	222,505	252,996	0.476011	68.00
69.00	06900	ELECTROCARDIOLOGY	938,603	3,774,313	4,712,916	0.108612	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	896,714	91,759	988,473	0.335925	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,373,797	4,535,233	13,909,030	0.242142	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,291,587	4,124,785	7,416,372	0.238806	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	4,000	1,282,894	1,286,894	0.183756	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	986,730	986,730		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	564,367	564,367		88.01
91.00	09100	EMERGENCY	1,996,630	18,561,754	20,558,384	0.137618	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	210,526	856,835	1,067,361	0.973966	92.00
200.00		Subtotal (see instructions)	51,009,651	153,661,745	204,671,396		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	51,009,651	153,661,745	204,671,396		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/31/2017 10:58 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
31.00	03100 INTENSIVE CARE UNIT		31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.181744	50.00
51.00	05100 RECOVERY ROOM	0.000000	51.00
53.00	05300 ANESTHESIOLOGY	0.006462	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.214229	54.00
54.01	03630 ULTRA SOUND	0.117251	54.01
56.00	05600 RADIOISOTOPE	0.185515	56.00
57.00	05700 CT SCAN	0.019987	57.00
58.00	05800 MRI	0.068980	58.00
60.00	06000 LABORATORY	0.071565	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.089678	62.00
65.00	06500 RESPIRATORY THERAPY	0.299970	65.00
66.00	06600 PHYSICAL THERAPY	0.197497	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.125913	67.00
68.00	06800 SPEECH PATHOLOGY	0.476011	68.00
69.00	06900 ELECTROCARDIOLOGY	0.108612	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.335925	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.242142	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.238806	73.00
74.00	07400 RENAL DIALYSIS	0.000000	74.00
76.00	03020 ACUPUNCTURE	0.000000	76.00
76.01	03610 SLEEP LAB	0.183756	76.01
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC		88.00
88.01	08801 RURAL HEALTH CLINIC II		88.01
91.00	09100 EMERGENCY	0.137618	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.973966	92.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0294

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2017 10:58 am

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		4,584,238	0	4,584,238	30.00
31.00	03100 INTENSIVE CARE UNIT		911,709	0	911,709	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		6,812,983	0	6,812,983	50.00
51.00	05100 RECOVERY ROOM		0	0	0	51.00
53.00	05300 ANESTHESIOLOGY		117,832	0	117,832	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,869,825	0	1,869,825	54.00
54.01	03630 ULTRA SOUND		357,403	0	357,403	54.01
56.00	05600 RADIOISOTOPE		460,250	0	460,250	56.00
57.00	05700 CT SCAN		634,790	0	634,790	57.00
58.00	05800 MRI		251,358	0	251,358	58.00
60.00	06000 LABORATORY		2,352,864	0	2,352,864	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		47,305	0	47,305	62.00
65.00	06500 RESPIRATORY THERAPY	0	693,040	0	693,040	65.00
66.00	06600 PHYSICAL THERAPY	0	787,276	0	787,276	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	306,906	0	306,906	67.00
68.00	06800 SPEECH PATHOLOGY	0	120,429	0	120,429	68.00
69.00	06900 ELECTROCARDIOLOGY		511,880	0	511,880	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		332,053	0	332,053	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		3,367,965	0	3,367,965	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,771,077	0	1,771,077	73.00
74.00	07400 RENAL DIALYSIS		0	0	0	74.00
76.00	03020 ACUPUNCTURE		0	0	0	76.00
76.01	03610 SLEEP LAB		236,474	0	236,474	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		747,113	0	747,113	88.00
88.01	08801 RURAL HEALTH CLINIC II		463,242	0	463,242	88.01
91.00	09100 EMERGENCY		2,829,209	0	2,829,209	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1,039,573	0	1,039,573	92.00
200.00	Subtotal (see instructions)	0	31,606,794	0	31,606,794	200.00
201.00	Less Observation Beds		1,039,573		1,039,573	201.00
202.00	Total (see instructions)	0	30,567,221	0	30,567,221	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0294

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

Worksheet C
Part I
Date/Time Prepared:
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		Title XIX			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,673,587		4,673,587		30.00
31.00	03100	INTENSIVE CARE UNIT	734,750		734,750		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,051,265	27,435,342	37,486,607	0.181744	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	4,894,502	13,339,114	18,233,616	0.006462	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,273,224	7,454,921	8,728,145	0.214229	54.00
54.01	03630	ULTRA SOUND	249,584	2,798,599	3,048,183	0.117251	54.01
56.00	05600	RADIOISOTOPE	281,412	2,199,523	2,480,935	0.185515	56.00
57.00	05700	CT SCAN	4,319,907	27,439,513	31,759,420	0.019987	57.00
58.00	05800	MRI	103,596	3,540,349	3,643,945	0.068980	58.00
60.00	06000	LABORATORY	4,671,228	28,205,883	32,877,111	0.071565	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	322,149	205,348	527,497	0.089678	62.00
65.00	06500	RESPIRATORY THERAPY	1,513,317	797,047	2,310,364	0.299970	65.00
66.00	06600	PHYSICAL THERAPY	752,343	3,233,927	3,986,270	0.197497	66.00
67.00	06700	OCCUPATIONAL THERAPY	426,439	2,011,004	2,437,443	0.125913	67.00
68.00	06800	SPEECH PATHOLOGY	30,491	222,505	252,996	0.476011	68.00
69.00	06900	ELECTROCARDIOLOGY	938,603	3,774,313	4,712,916	0.108612	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	896,714	91,759	988,473	0.335925	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,373,797	4,535,233	13,909,030	0.242142	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,291,587	4,124,785	7,416,372	0.238806	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	4,000	1,282,894	1,286,894	0.183756	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	986,730	986,730	0.757161	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	564,367	564,367	0.820817	88.01
91.00	09100	EMERGENCY	1,996,630	18,561,754	20,558,384	0.137618	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	210,526	856,835	1,067,361	0.973966	92.00
200.00		Subtotal (see instructions)	51,009,651	153,661,745	204,671,396		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	51,009,651	153,661,745	204,671,396		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/31/2017 10:58 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630 ULTRA SOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.00	03020 ACUPUNCTURE	0.000000		76.00
76.01	03610 SLEEP LAB	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		88.01
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0294		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part I Date/Time Prepared: 5/31/2017 10:58 am	
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	1,141,343	0	1,141,343	3,078	370.81	30.00
31.00	INTENSIVE CARE UNIT	227,724		227,724	215	1,059.18	31.00
200.00	Total (Lines 30-199)	1,369,067		1,369,067	3,293		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	1,488	551,765				
31.00	INTENSIVE CARE UNIT	142	150,404				
200.00	Total (Lines 30-199)	1,630	702,169				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 5/31/2017 10:58 am
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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	817,718	37,486,607	0.021814	4,584,088	99,997	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	18,764	18,233,616	0.001029	2,207,737	2,272	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	222,437	8,728,145	0.025485	829,861	21,149	54.00
54.01	03630	ULTRA SOUND	29,598	3,048,183	0.009710	162,833	1,581	54.01
56.00	05600	RADIOISOTOPE	26,106	2,480,935	0.010523	227,597	2,395	56.00
57.00	05700	CT SCAN	28,996	31,759,420	0.000913	2,597,780	2,372	57.00
58.00	05800	MRI	5,449	3,643,945	0.001495	76,634	115	58.00
60.00	06000	LABORATORY	191,709	32,877,111	0.005831	3,017,907	17,597	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,466	527,497	0.014154	254,388	3,601	62.00
65.00	06500	RESPIRATORY THERAPY	73,760	2,310,364	0.031926	958,417	30,598	65.00
66.00	06600	PHYSICAL THERAPY	38,543	3,986,270	0.009669	490,856	4,746	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,635	2,437,443	0.002722	273,691	745	67.00
68.00	06800	SPEECH PATHOLOGY	2,149	252,996	0.008494	24,742	210	68.00
69.00	06900	ELECTROCARDIOLOGY	13,959	4,712,916	0.002962	713,108	2,112	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,969	988,473	0.011097	623,521	6,919	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	112,993	13,909,030	0.008124	4,039,645	32,818	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,415	7,416,372	0.010304	1,874,929	19,319	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	6,202	1,286,894	0.004819	3,969	19	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	11,883	986,730	0.012043	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,525	564,367	0.013334	0	0	88.01
91.00	09100	EMERGENCY	334,535	20,558,384	0.016272	1,211,024	19,706	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	258,824	1,067,361	0.242490	126,100	30,578	92.00
200.00		Total (Lines 50-199)	2,302,635	199,263,059		24,298,827	298,849	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0294		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part III Date/Time Prepared: 5/31/2017 10:58 am	
Cost Center Description			Title XVIII		Hospital		PPS	
			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	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00	
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	3,078	0.00	1,488	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	215	0.00	142	0	31.00	
200.00		Total (lines 30-199)	3,293		1,630	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/31/2017 10:58 am
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Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
54.01	03630	ULTRASOUND	0	0	0	0	0 54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0 62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0 76.00
76.01	03610	SLEEP LAB	0	0	0	0	0 76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0 88.01
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
200.00		Total (lines 50-199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/31/2017 10:58 am
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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 Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	37,486,607	0.000000	0.000000	4,584,088	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
53.00	05300 ANESTHESIOLOGY	0	18,233,616	0.000000	0.000000	2,207,737	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	8,728,145	0.000000	0.000000	829,861	54.00
54.01	03630 ULTRA SOUND	0	3,048,183	0.000000	0.000000	162,833	54.01
56.00	05600 RADIOISOTOPE	0	2,480,935	0.000000	0.000000	227,597	56.00
57.00	05700 CT SCAN	0	31,759,420	0.000000	0.000000	2,597,780	57.00
58.00	05800 MRI	0	3,643,945	0.000000	0.000000	76,634	58.00
60.00	06000 LABORATORY	0	32,877,111	0.000000	0.000000	3,017,907	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	527,497	0.000000	0.000000	254,388	62.00
65.00	06500 RESPIRATORY THERAPY	0	2,310,364	0.000000	0.000000	958,417	65.00
66.00	06600 PHYSICAL THERAPY	0	3,986,270	0.000000	0.000000	490,856	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,437,443	0.000000	0.000000	273,691	67.00
68.00	06800 SPEECH PATHOLOGY	0	252,996	0.000000	0.000000	24,742	68.00
69.00	06900 ELECTROCARDIOLOGY	0	4,712,916	0.000000	0.000000	713,108	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	988,473	0.000000	0.000000	623,521	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	13,909,030	0.000000	0.000000	4,039,645	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7,416,372	0.000000	0.000000	1,874,929	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610 SLEEP LAB	0	1,286,894	0.000000	0.000000	3,969	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	986,730	0.000000	0.000000	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	564,367	0.000000	0.000000	0	88.01
91.00	09100 EMERGENCY	0	20,558,384	0.000000	0.000000	1,211,024	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1,067,361	0.000000	0.000000	126,100	92.00
200.00	Total (lines 50-199)	0	199,263,059			24,298,827	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/31/2017 10:58 am
Title XVIII		Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	7,118,717	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	3,364,553	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	2,080,516	0	54.00
54.01	03630 ULTRA SOUND	0	974,002	0	54.01
56.00	05600 RADIOISOTOPE	0	823,653	0	56.00
57.00	05700 CT SCAN	0	8,047,663	0	57.00
58.00	05800 MRI	0	1,035,191	0	58.00
60.00	06000 LABORATORY	0	3,108,539	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	86,289	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	202,793	0	65.00
66.00	06600 PHYSICAL THERAPY	0	23,028	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	11,886	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,329	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,303,608	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	34,013	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,202,774	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,171,236	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0	76.00
76.01	03610 SLEEP LAB	0	365,148	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	88.01
91.00	09100 EMERGENCY	0	3,887,091	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	258,252	0	92.00
200.00	Total (Lines 50-199)	0	35,100,281	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/31/2017 10:58 am
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	0.181744	7,118,717	0	0	1,293,784	50.00
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0.006462	3,364,553	0	0	21,742	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.214229	2,080,516	0	0	445,707	54.00
54.01 03630 ULTRA SOUND	0.117251	974,002	0	0	114,203	54.01
56.00 05600 RADIOISOTOPE	0.185515	823,653	0	0	152,800	56.00
57.00 05700 CT SCAN	0.019987	8,047,663	0	0	160,849	57.00
58.00 05800 MRI	0.068980	1,035,191	0	0	71,407	58.00
60.00 06000 LABORATORY	0.071565	3,108,539	0	0	222,463	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.089678	86,289	0	0	7,738	62.00
65.00 06500 RESPIRATORY THERAPY	0.299970	202,793	0	0	60,832	65.00
66.00 06600 PHYSICAL THERAPY	0.197497	23,028	0	0	4,548	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.125913	11,886	0	0	1,497	67.00
68.00 06800 SPEECH PATHOLOGY	0.476011	1,329	0	0	633	68.00
69.00 06900 ELECTROCARDIOLOGY	0.108612	1,303,608	0	0	141,587	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.335925	34,013	0	0	11,426	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.242142	1,202,774	0	0	291,242	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.238806	1,171,236	0	8,974	279,698	73.00
74.00 07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00 03020 ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01 03610 SLEEP LAB	0.183756	365,148	0	0	67,098	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0.000000				0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0.000000				0	88.01
91.00 09100 EMERGENCY	0.137618	3,887,091	0	0	534,934	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.973966	258,252	0	0	251,529	92.00
200.00 Subtotal (see instructions)		35,100,281	0	8,974	4,135,717	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 +/- line 201)		35,100,281	0	8,974	4,135,717	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/31/2017 10:58 am
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
51.00 05100 RECOVERY ROOM	0	0		51.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 03630 ULTRA SOUND	0	0		54.01
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
60.00 06000 LABORATORY	0	0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2,143		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03020 ACUPUNCTURE	0	0		76.00
76.01 03610 SLEEP LAB	0	0		76.01
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		88.01
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	0	2,143		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	2,143		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/31/2017 10:58 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,078	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,078	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)		2,380	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)		1,488	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)		4,584,238	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)		4,584,238	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)		4,584,238	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)		1,489.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,216,168	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)		2,216,168	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/31/2017 10:58 am		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)					42.00	
Intensive Care Type Inpatient Hospital Units							
43.00	911,709	215	4,240.51	142	602,152	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)					3,816,191	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,634,511	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)					702,169	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					298,849	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,001,018	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,633,493	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)					698	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,489.36	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,039,573	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0294		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/31/2017 10:58 am	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,141,343	4,584,238	0.248971	1,039,573	258,824	90.00
91.00	Nursing School cost	0	4,584,238	0.000000	1,039,573	0	91.00
92.00	Allied health cost	0	4,584,238	0.000000	1,039,573	0	92.00
93.00	All other Medical Education	0	4,584,238	0.000000	1,039,573	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/31/2017 10:58 am	
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		2,934,497	30.00
31.00	03100	INTENSIVE CARE UNIT		484,463	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.181744	4,584,088	833,130 50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0 51.00
53.00	05300	ANESTHESIOLOGY	0.006462	2,207,737	14,266 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.214229	829,861	177,780 54.00
54.01	03630	ULTRA SOUND	0.117251	162,833	19,092 54.01
56.00	05600	RADIOISOTOPE	0.185515	227,597	42,223 56.00
57.00	05700	CT SCAN	0.019987	2,597,780	51,922 57.00
58.00	05800	MRI	0.068980	76,634	5,286 58.00
60.00	06000	LABORATORY	0.071565	3,017,907	215,977 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.089678	254,388	22,813 62.00
65.00	06500	RESPIRATORY THERAPY	0.299970	958,417	287,496 65.00
66.00	06600	PHYSICAL THERAPY	0.197497	490,856	96,943 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.125913	273,691	34,461 67.00
68.00	06800	SPEECH PATHOLOGY	0.476011	24,742	11,777 68.00
69.00	06900	ELECTROCARDIOLOGY	0.108612	713,108	77,452 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.335925	623,521	209,456 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.242142	4,039,645	978,168 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.238806	1,874,929	447,744 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0 74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0 76.00
76.01	03610	SLEEP LAB	0.183756	3,969	729 76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0 88.01
91.00	09100	EMERGENCY	0.137618	1,211,024	166,659 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.973966	126,100	122,817 92.00
200.00		Total (sum of lines 50-94 and 96-98)		24,298,827	3,816,191 200.00
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)		24,298,827	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/31/2017 10:58 am
		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)		2,681,430	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		769,765	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)		238,160	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)		45.09	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)		4.83	30.00
31.00	Percentage of Medicaid patient days (see instructions)		14.72	31.00
32.00	Sum of lines 30 and 31		19.55	32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.46	33.00
34.00	Disproportionate share adjustment (see instructions)		47,109	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/31/2017 10:58 am
		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)	0.000019507	0.000018796	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	124,965	112,355	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	93,553	28,320	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	121,873		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)	3,858,337		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	5,142,890		48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		4,821,752	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		339,425	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)		5,161,177	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		5,161,177	61.00
62.00	Deductibles billed to program beneficiaries		440,356	62.00
63.00	Coinurance billed to program beneficiaries		19,642	63.00
64.00	Allowable bad debts (see instructions)		124,906	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		81,189	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		94,458	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		4,782,368	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)		-3,141	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-9,995	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-11,375	70.93
70.94	HRR adjustment amount (see instructions)		-35,853	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/31/2017 10:58 am	
		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)	0		0	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)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			4,722,004	71.00
71.01	Sequestration adjustment (see instructions)			94,440	71.01
72.00	Interim payments			4,741,229	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)			-113,665	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			439,109	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)		721,245	242,170	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.9964291866	0.9976610800	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		-2,575	-566	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.9895	0.9900	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-7,573	-2,422	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/31/2017 10:58 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,143	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,135,717	2.00
3.00	PPS payments		3,036,866	3.00
4.00	Outlier payment (see instructions)		7,597	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)		2,143	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		8,974	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)		8,974	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)		8,974	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		6,831	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)		2,143	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)		3,044,463	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)		632,457	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)		2,414,149	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,414,149	30.00
31.00	Primary payer payments		125	31.00
32.00	Subtotal (line 30 minus line 31)		2,414,024	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)		163,861	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		106,510	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		139,204	36.00
37.00	Subtotal (see instructions)		2,520,534	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,520,534	40.00
40.01	Sequestration adjustment (see instructions)		50,411	40.01
41.00	Interim payments		2,496,859	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-26,736	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: 14-0294

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

Worksheet E-1
Part I
Date/Time Prepared:
5/31/2017 10:58 am

		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		4,741,229		2,467,359	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	08/19/2016	29,500	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		29,500	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)		4,741,229		2,496,859	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		113,665		26,736	6.02	
7.00	Total Medicare program liability (see instructions)		4,627,564		2,470,123	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: 14-0294
Component CCN: 14-U294

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

Worksheet E-1
Part I
Date/Time Prepared:
5/31/2017 10:58 am

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		0		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)		0		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)		0		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: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/31/2017 10:58 am
		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		866	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		1,630	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		154	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		2,595	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		204,671,396	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		609,589	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: 14-0294 Component CCN: 14-U294	Period: From 01/01/2016 To 12/31/2016	Worksheet E-2 Date/Time Prepared: 5/31/2017 10:58 am
		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)	0	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	0	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)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	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)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	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)	0	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)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
20.00	Interim payments	0	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

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

Provider CCN: 14-0294

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

Worksheet G

Date/Time Prepared:
5/31/2017 10:58 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-521,201	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	-977,227	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,230,247	0	0	0	6.00
7.00	Inventory	2,133,146	0	0	0	7.00
8.00	Prepaid expenses	429,202	0	0	0	8.00
9.00	Other current assets	159,902	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	-6,425	0	0	0	11.00
FIXED ASSETS						
12.00	Land	961,157	0	0	0	12.00
13.00	Land improvements	411,367	0	0	0	13.00
14.00	Accumulated depreciation	-191,839	0	0	0	14.00
15.00	Buildings	28,865,854	0	0	0	15.00
16.00	Accumulated depreciation	-9,534,141	0	0	0	16.00
17.00	Leasehold improvements	5,836,046	0	0	0	17.00
18.00	Accumulated depreciation	-2,555,525	0	0	0	18.00
19.00	Fixed equipment	2,236,145	0	0	0	19.00
20.00	Accumulated depreciation	-1,163,692	0	0	0	20.00
21.00	Automobiles and trucks	28,013	0	0	0	21.00
22.00	Accumulated depreciation	-19,605	0	0	0	22.00
23.00	Major movable equipment	10,105,763	0	0	0	23.00
24.00	Accumulated depreciation	-7,848,106	0	0	0	24.00
25.00	Minor equipment depreciable	3,400,808	0	0	0	25.00
26.00	Accumulated depreciation	-2,608,768	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	27,923,477	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	-12,209,557	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-12,209,557	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	15,707,495	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	889,540	0	0	0	37.00
38.00	Salaries, wages, and fees payable	771,993	0	0	0	38.00
39.00	Payroll taxes payable	93,754	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	-12,832,333	0	0	0	43.00
44.00	Other current liabilities	308,820	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-10,768,226	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-10,768,226	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	26,475,721				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	26,475,721	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	15,707,495	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0294

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

Worksheet G-1

Date/Time Prepared:
5/31/2017 10:58 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		21,526,551		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		4,949,168			2.00
3.00	Total (sum of line 1 and line 2)		26,475,719		0	3.00
4.00	ROUNDING	2		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		2		0	10.00
11.00	Subtotal (line 3 plus line 10)		26,475,721		0	11.00
12.00		0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		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)		26,475,721		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	ROUNDING		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			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: 14-0294

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/31/2017 10:58 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,673,587		4,673,587	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,673,587		4,673,587	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	734,750		734,750	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)	734,750		734,750	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,408,337		5,408,337	17.00
18.00	Ancillary services	43,390,158	132,696,059	176,086,217	18.00
19.00	Outpatient services	2,207,156	19,418,589	21,625,745	19.00
20.00	RURAL HEALTH CLINIC	0	637,705	637,705	20.00
20.01	RURAL HEALTH CLINIC II	0	564,367	564,367	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PROFESSIONAL FEES	0	451,298	451,298	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	51,005,651	153,768,018	204,773,669	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		36,020,303		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)		36,020,303		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0294

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

Worksheet G-3

Date/Time Prepared:
5/31/2017 10:58 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	204,773,669	1.00
2.00	Less contractual allowances and discounts on patients' accounts	163,919,979	2.00
3.00	Net patient revenues (line 1 minus line 2)	40,853,690	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	36,020,303	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,833,387	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	115,781	24.00
25.00	Total other income (sum of lines 6-24)	115,781	25.00
26.00	Total (line 5 plus line 25)	4,949,168	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)	4,949,168	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0294	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/31/2017 10:58 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		273,447	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		65,978	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)		7.09	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)		339,425	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: 14-0294

Period: From 01/01/2016

Worksheet M-1

Component CCN: 14-8524

To 12/31/2016

Date/Time Prepared: 5/31/2017 10:58 am

		RHC I		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	140,614	0	140,614	0	140,614	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	85,871	0	85,871	0	85,871	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	44,051	0	44,051	0	44,051	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	14,322	14,322	0	14,322	8.00
9.00	Other Facility Health Care Staff Costs	25,406	0	25,406	0	25,406	9.00
10.00	Subtotal (sum of lines 1 through 9)	295,942	14,322	310,264	0	310,264	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	23,125	23,125	0	23,125	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	23,125	23,125	0	23,125	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	295,942	37,447	333,389	0	333,389	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	21,015	21,015	0	21,015	29.00
30.00	Administrative Costs	92,239	42,014	134,253	0	134,253	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	92,239	63,029	155,268	0	155,268	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	388,181	100,476	488,657	0	488,657	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294

Period: From 01/01/2016

Worksheet M-1

Component CCN: 14-8524

To 12/31/2016

Date/Time Prepared: 5/31/2017 10:58 am

		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	140,614		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	85,871		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	44,051		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	14,322		8.00
9.00	Other Facility Health Care Staff Costs	0	25,406		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	310,264		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	23,125		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	23,125		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	333,389		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	21,015		29.00
30.00	Administrative Costs	0	134,253		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	155,268		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	488,657		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294

Period: From 01/01/2016

Worksheet M-1

Component CCN: 14-8523

To 12/31/2016

Date/Time Prepared: 5/31/2017 10:58 am

		RHC II		Cost		
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	1.00
2.00	Physician Assistant	99,768	0	99,768	0	2.00
3.00	Nurse Practitioner	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	4.00
5.00	Other Nurse	33,841	0	33,841	0	5.00
6.00	Clinical Psychologist	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	7.00
8.00	Laboratory Technician	0	28,806	28,806	0	8.00
9.00	Other Facility Health Care Staff Costs	6,256	0	6,256	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	139,865	28,806	168,671	0	10.00
11.00	Physician Services Under Agreement	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	14.00
15.00	Medical Supplies	0	23,169	23,169	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	23,169	23,169	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	139,865	51,975	191,840	0	22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	23.00
24.00	Dental	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	43,551	43,551	0	29.00
30.00	Administrative Costs	45,675	33,765	79,440	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	45,675	77,316	122,991	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	185,540	129,291	314,831	0	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294

Period:

Worksheet M-1

Component CCN: 14-8523

From 01/01/2016
To 12/31/2016

Date/Time Prepared:
5/31/2017 10:58 am

RHC II

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	99,768	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	33,841	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	28,806	8.00
9.00	Other Facility Health Care Staff Costs	0	6,256	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	168,671	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	23,169	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	23,169	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	191,840	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	43,551	29.00
30.00	Administrative Costs	0	79,440	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	122,991	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	314,831	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0294 Component CCN: 14-8524	Period: From 01/01/2016 To 12/31/2016	Worksheet M-2 Date/Time Prepared: 5/31/2017 10:58 am
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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	0.95	4,074	4,200	3,990	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.96	2,134	2,100	2,016	3.00
4.00	Subtotal (sum of lines 1 through 3)	1.91	6,208		6,006	4.00
5.00	Visiting Nurse	0.00	3			5.00
6.00	Clinical Psychologist	0.00	0			6.00
7.00	Clinical Social Worker	0.00	0			7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.91	6,211			8.00
9.00	Physician Services Under Agreements		0			9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				333,389	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				333,389	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				155,268	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				258,456	15.00
16.00	Total overhead (sum of lines 14 and 15)				413,724	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				413,724	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				413,724	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				747,113	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0294 Component CCN: 14-8523	Period: From 01/01/2016 To 12/31/2016	Worksheet M-2 Date/Time Prepared: 5/31/2017 10:58 am
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		RHC II		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.00	0	4,200	0	1.00
2.00	Physician Assistant	0.94	3,271	2,100	1,974	2.00
3.00	Nurse Practitioner	0.00	0	2,100	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.94	3,271		1,974	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.94	3,271		3,271	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				191,840	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				191,840	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				122,991	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				148,411	15.00
16.00	Total overhead (sum of lines 14 and 15)				271,402	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				271,402	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				271,402	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				463,242	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0294 Component CCN: 14-8524	Period: From 01/01/2016 To 12/31/2016	Worksheet M-3 Date/Time Prepared: 5/31/2017 10:58 am	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			747,113	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			7,310	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			739,803	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,211	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			6,211	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			119.11	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)		119.11	119.11	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		1,944	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		231,550	0	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	231,550	16.00
16.01	Total program charges (see instructions)(from contractor's records)			359,151	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			58,581	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			37,768	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.)			135,205	16.04
16.05	Total program cost (see instructions)		0	172,973	16.05
17.00	Primary payer amounts			235	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			24,776	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			55,159	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			172,738	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			7,310	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			180,048	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
26.00	Net reimbursable amount (see instructions)			180,048	26.00
26.01	Sequestration adjustment (see instructions)			3,601	26.01
27.00	Interim payments			145,023	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)			31,424	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0294 Component CCN: 14-8523	Period: From 01/01/2016 To 12/31/2016	Worksheet M-3 Date/Time Prepared: 5/31/2017 10:58 am	
		Title XVIII	RHC II	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			463,242	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			30,790	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			432,452	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,271	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			3,271	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			132.21	7.00
		Calculation of Limit (1)			
		Prior to January 1		On or After January 1	
		1.00		2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		132.21	132.21	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		1,061	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		140,275	0	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	140,275	16.00
16.01	Total program charges (see instructions)(from contractor's records)			168,131	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			32,359	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			26,998	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.)			74,643	16.04
16.05	Total program cost (see instructions)		0	101,641	16.05
17.00	Primary payer amounts			37	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			19,973	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			23,160	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			101,604	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			30,790	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			132,394	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
26.00	Net reimbursable amount (see instructions)			132,394	26.00
26.01	Sequestration adjustment (see instructions)			2,648	26.01
27.00	Interim payments			86,561	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)			43,185	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: 14-0294 Component CCN: 14-8524	Period: From 01/01/2016 To 12/31/2016	Worksheet M-4 Date/Time Prepared: 5/31/2017 10:58 am	
		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)		310,264	310,264	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.002917	0.007414	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		905	2,300	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		40	17	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		945	2,317	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		333,389	333,389	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		413,724	413,724	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.002835	0.006950	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		1,173	2,875	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		2,118	5,192	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		48	122	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		44.13	42.56	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		48	122	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		2,118	5,192	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)			7,310	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)			7,310	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0294 Component CCN: 14-8523	Period: From 01/01/2016 To 12/31/2016	Worksheet M-4 Date/Time Prepared: 5/31/2017 10:58 am	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		168,671	168,671	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.030989	0.044269	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		5,227	7,467	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		40	17	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		5,267	7,484	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		191,840	191,840	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		271,402	271,402	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.027455	0.039012	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		7,451	10,588	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		12,718	18,072	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		63	90	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		201.87	200.80	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		63	90	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		12,718	18,072	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)			30,790	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)			30,790	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0294 Component CCN: 14-8524	Period: From 01/01/2016 To 12/31/2016	Worksheet M-5 Date/Time Prepared: 5/31/2017 10:58 am
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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		145,023	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)		145,023	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		31,424	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		176,447	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0294 Component CCN: 14-8523	Period: From 01/01/2016 To 12/31/2016	Worksheet M-5 Date/Time Prepared: 5/31/2017 10:58 am
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		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		86,561	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)		86,561	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		43,185	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		129,746	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00