

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141308	Period: From 05/01/2015 To 04/30/2016	Worksheet S Parts I-III Date/Time Prepared: 9/6/2016 1:30 pm
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 9/6/2016	Time: 1:30 pm
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WASHINGTON COUNTY HOSPITAL ( 141308 ) for the cost reporting period beginning 05/01/2015 and ending 04/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	4,830	163,171	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	85,206	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		-9,178		0	10.00
200.00 Total	0	90,036	153,993	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: 141308			Period: From 05/01/2015 To 04/30/2016		Worksheet S-2 Part I Date/Time Prepared: 9/3/2016 10:00 am						
1.00		2.00		3.00		4.00							
Hospital and Hospital Health Care Complex Address:													
1.00	Street: 705 SOUTH GRAND AVENUE			PO Box:						1.00			
2.00	City: NASHVILLE			State: IL		Zip Code: 62263		County: WASHINGTON		2.00			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00			
		V		XVIII		XIX							
3.00	Hospital and Hospital-Based Component Identification:												
3.00	Hospital		WASHINGTON COUNTY HOSPITAL	141308	99914	1	12/01/2000	N	0	0	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		WASHINGTON COUNTY SWING BED	14Z308	99914		08/18/2000	N	0	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		WASHINGTON COUNTY EXTENDED CARE								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		GRAND STREET RHC	143472	99914		08/01/2005	N	0	N	15.00		
16.00	Hospital-Based Health Clinic - FQHC										16.00		
17.00	Hospital-Based (CMHC) I										17.00		
18.00	Renal Dialysis										18.00		
19.00	Other										19.00		
							From:	To:					
							1.00	2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)						05/01/2015	04/30/2016		20.00			
21.00	Type of Control (see instructions)						11			21.00			
Inpatient PPS Information													
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (PickLe amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N	N		22.00			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	N		22.01			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03			
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							3	N		23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days						
		1.00	2.00	3.00	4.00	5.00	6.00						
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.						0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.						0	0	0	0	0	0	25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141308	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part I Date/Time Prepared: 9/3/2016 10:00 am			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N				37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
<b>Prospective Payment System (PPS)-Capital</b>							
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	
<b>Teaching Hospitals</b>							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	0.00	0.00				61.06
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00	2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00		61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00		61.20	
					1.00		
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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				
64.00	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. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	

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		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
				1.00	2.00	3.00
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
				1.00		
<b>Long Term Care Hospital PPS</b>						
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
<b>TEFRA Providers</b>						
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.			N		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	
<b>Title V and XIX Services</b>						
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	N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V		XIX				
		1.00		2.00				
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00		
<b>Rural Providers</b>								
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y				105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y				106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N				107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y				108.00		
		Physical	Occupational	Speech	Respiratory			
		1.00	2.00	3.00	4.00			
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00	
					1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.	N					110.00	
					1.00	2.00	3.00	
<b>Miscellaneous Cost Reporting Information</b>								
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.	Y				117.00		
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00		
		Premiums		Losses		Insurance		
		1.00		2.00		3.00		
118.01	List amounts of malpractice premiums and paid losses:	11,705		0		0		
					1.00		2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02		
119.00	DO NOT USE THIS LINE					119.00		
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00		
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00		
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00		
<b>Transplant Center Information</b>								
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00		
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00		
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00		
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00		
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00		
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00		
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141308	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part I Date/Time Prepared: 9/3/2016 10:00 am		
		1.00	2.00			
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00
		1.00	2.00	3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00
142.00	Street:	PO Box:				142.00
143.00	City:	State:		Zip Code:		143.00
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?		Y			144.00
				1.00 2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00
				1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N			147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N			148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N			149.00
		Part A		Part B		Title V
		1.00		2.00		3.00
						Title XIX
						4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
				1.00		
165.00	Multi campus 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
		0	1.00	2.00	3.00	4.00
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
				1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y			167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0
168.01	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141308	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part I Date/Time Prepared: 9/3/2016 10:00 am
			Beginning 1.00	Ending 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)		05/01/2015	04/30/2016 170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N 171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141308	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part II Date/Time Prepared: 9/3/2016 10:00 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	08/01/2016	Y	08/01/2016
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: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet S-2  
Part II  
Date/Time Prepared:  
9/3/2016 10:00 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N	N	21.00
					1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>						
<b>Capital Related Cost</b>						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N		27.00
<b>Interest Expense</b>						
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			Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N		31.00
<b>Purchased Services</b>						
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.					33.00
<b>Provider-Based Physicians</b>						
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	
<b>Home Office Costs</b>						
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					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.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
				1.00	2.00	
<b>Cost Report Preparer Contact Information</b>						
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.	ELAI NE		MATZENBACHER		41.00
42.00	Enter the employer/company name of the cost report preparer.	WASHINGTON COUNTY HOSPITAL				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-327-2207		EMATZENBACHER@WASHINGTONCOUNTYHOSPITAL		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet S-2  
Part II  
Date/Time Prepared:  
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		3.00	
<b>Cost Report Preparer Contact Information</b>			
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.	CFO	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: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/3/2016 10:00 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	22	8,052	5,304.00	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)		22	8,052	5,304.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		22	8,052	5,304.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	28	10,248			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	115.00					23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		50				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: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/3/2016 10:00 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)	178	16	221			1.00
2.00 HMO and other (see instructions)	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	1,468	0	1,551			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	166			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,646	16	1,938			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	1,646	16	1,938	0.00	103.55	14.00
15.00 CAH visits	8,703	3,717	25,242			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			9,013	0.00	16.97	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				0.00	0.00	23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	2,296	0	7,842	0.00	12.46	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	132.98	27.00
28.00 Observation Bed Days		0	23			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: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/3/2016 10:00 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	59	5	79	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	59	5	79	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00				24	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	0.00					23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141308 Component CCN: 143472		Period: From 05/01/2015 To 04/30/2016		Worksheet S-8 Date/Time Prepared: 9/3/2016 10:00 am	
				Rural Health Clinic (RHC) I		Cost	
				1.00			
1.00	Clinic Address and Identification			705 SOUTH GRAND AVE		1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00	City, State, ZIP Code, County			NASHVILLE		IL62263	
				1.00			
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0	
				Grant Award		Date	
				1.00		2.00	
		Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00	
7.00	Appalachian Regional Commission			0		7.00	
8.00	Look-Alikes			0		8.00	
9.00	OTHER (SPECIFY)			0		9.00	
				1.00		2.00	
10.00	Does this facility operate as other than an RHC or FOHC? 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		from to		from	
		1.00 2.00		3.00 4.00		5.00	
11.00	Facility hours of operations (1)			07:30		19:00	
		Clinic		07:30		07:30	
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0	
				Provider name		CCN number	
				1.00		2.00	
14.00	Provider name, CCN number			XVIII		XIX	
		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			WASHINGTON		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)			19:00		07:30	
		Clinic		07:30		19:00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141308 Component CCN: 143472	Period: From 05/01/2015 To 04/30/2016	Worksheet S-8 Date/Time Prepared: 9/3/2016 10:00 am
		Rural Health Clinic (RHC) I	Cost

	Friday		Saturday			
	from	to	from	to		
	11.00	07:30	19:00	08:00		

Facility hours of operations (1)

Clinic

07:30

19:00

08:00

14:00

11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141308	Period: From 05/01/2015 To 04/30/2016	Worksheet S-10 Date/Time Prepared: 9/3/2016 10:00 am
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.670468	1.00	
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		1,624,575	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		2,911,489	6.00	
7.00	Medicaid cost (line 1 times line 6)		1,952,060	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)		327,485	8.00	
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
<b>Other state or local government indigent care program (see instructions for each line)</b>					
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	
<b>Uncompensated care (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		327,485	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	90,475	20,624	111,099	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	60,661	13,828	74,489	21.00
22.00	Partial payment by patients approved for charity care	1,171	3,386	4,557	22.00
23.00	Cost of charity care (line 21 minus line 22)	59,490	10,442	69,932	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		442,431	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		69,634	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		372,797	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		249,948	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		319,880	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		647,365	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet A  
Date/Time Prepared:  
9/3/2016 10:00 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT		277,468	277,468	60,964	338,432	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		311,260	311,260	0	311,260	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	78,269	2,049,866	2,128,135	0	2,128,135	4.00
5.01	00550	INFORMATION SYSTEMS	252,565	311,768	564,333	-52,081	512,252	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	757,774	524,495	1,282,269	25,910	1,308,179	5.02
6.00	00600	MAINTENANCE & REPAIRS	115,043	410,652	525,695	0	525,695	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	87,445	87,445	0	87,445	8.00
9.00	00900	HOUSEKEEPING	200,672	24,729	225,401	0	225,401	9.00
10.00	01000	DIETARY	233,740	143,928	377,668	-32,404	345,264	10.00
11.00	01100	CAFETERIA	0	0	0	32,404	32,404	11.00
13.00	01300	NURSING ADMINISTRATION	84,731	200	84,931	0	84,931	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	54,905	17,678	72,583	0	72,583	14.00
15.00	01500	PHARMACY	120,097	19,477	139,574	0	139,574	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	187,796	39,833	227,629	0	227,629	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	4,616	4,616	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	204,088	0	204,088	14,800	218,888	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	575,871	30,137	606,008	-4,616	601,392	30.00
46.00	04600	OTHER LONG TERM CARE	539,405	27,387	566,792	0	566,792	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	139,310	104,788	244,098	0	244,098	50.00
53.00	05300	ANESTHESIOLOGY	0	36,929	36,929	-14,800	22,129	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	301,976	301,439	603,415	52,081	655,496	54.00
60.00	06000	LABORATORY	375,610	534,036	909,646	0	909,646	60.00
65.00	06500	RESPIRATORY THERAPY	27,949	63,951	91,900	0	91,900	65.00
66.00	06600	PHYSICAL THERAPY	784,444	43,804	828,248	0	828,248	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
68.01	06801	CARDIAC REHAB	50,766	3,919	54,685	0	54,685	68.01
69.00	06900	ELECTROCARDIOLOGY	4,877	13,234	18,111	0	18,111	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	67,619	67,619	-10,132	57,487	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,132	10,132	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	761,075	761,075	0	761,075	73.00
76.00	03480	ONCOLOGY	5,565	196	5,761	0	5,761	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	1,227,160	274,046	1,501,206	-25,910	1,475,296	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	426,380	1,225,034	1,651,414	0	1,651,414	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0	63,579	63,579	-63,579	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,748,993	7,769,972	14,518,965	-2,615	14,516,350	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,094	4,094	2,615	6,709	190.00
190.01	19001	OUTPATIENT CLINIC	483	314	797	0	797	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	6,749,476	7,774,380	14,523,856	0	14,523,856	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet A  
Date/Time Prepared:  
9/3/2016 10:00 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	338,432	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-91,802	219,458	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,128,135	4.00
5.01	00550	INFORMATION SYSTEMS	0	512,252	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	-35,023	1,273,156	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	525,695	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	87,445	8.00
9.00	00900	HOUSEKEEPING	0	225,401	9.00
10.00	01000	DIETARY	0	345,264	10.00
11.00	01100	CAFETERIA	-14,084	18,320	11.00
13.00	01300	NURSING ADMINISTRATION	0	84,931	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-608	71,975	14.00
15.00	01500	PHARMACY	0	139,574	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,125	225,504	16.00
17.00	01700	SOCIAL SERVICE	0	4,616	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	218,888	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	601,392	30.00
46.00	04600	OTHER LONG TERM CARE	0	566,792	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	244,098	50.00
53.00	05300	ANESTHESIOLOGY	0	22,129	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-6,369	649,127	54.00
60.00	06000	LABORATORY	-1,036	908,610	60.00
65.00	06500	RESPIRATORY THERAPY	-111	91,789	65.00
66.00	06600	PHYSICAL THERAPY	0	828,248	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
68.01	06801	CARDIAC REHAB	0	54,685	68.01
69.00	06900	ELECTROCARDIOLOGY	-13,234	4,877	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	57,487	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,132	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-116,538	644,537	73.00
76.00	03480	ONCOLOGY	0	5,761	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	-114,594	1,360,702	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-205,653	1,445,761	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-601,177	13,915,173	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,709	190.00
190.01	19001	OUTPATIENT CLINIC	0	797	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	190.02
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	-601,177	13,922,679	200.00

RECLASSIFICATIONS

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet A-6

Date/Time Prepared:  
9/3/2016 10:00 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
<b>A - RECLASSIFY CAFETERIA COSTS</b>						
1.00	CAFETERIA	11.00	20,055	12,349	1.00	
	TOTALS		20,055	12,349		
<b>B - RECLASS SOCIAL SERVICE COST</b>						
1.00	SOCIAL SERVICE	17.00	4,616	0	1.00	
	TOTALS		4,616	0		
<b>C - RECLASS PROFESSIONAL LIABILITY INSUR</b>						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	35,285	1.00	
	TOTALS		0	35,285		
<b>D - RECLASSIFY XRAY DIRECTORS SALARY</b>						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	52,081	0	1.00	
	TOTALS		52,081	0		
<b>E - RECLASSIFY ANESTHESIA PRO FEES</b>						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	14,800	1.00	
	TOTALS		0	14,800		
<b>F - INTEREST EXPENSE</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	63,579	1.00	
	TOTALS		0	63,579		
<b>G - TO RECLASS INTEROCULAR LENS</b>						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,132	1.00	
	TOTALS		0	10,132		
<b>H - TO RECLASS ANNEX BLDG DEPRECIATION</b>						
1.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	2,615	1.00	
	TOTALS		0	2,615		
<b>J - TO RCLS PHYS RECRUIT EXP FOR CLINIC</b>						
1.00	RURAL HEALTH CLINIC	88.00	0	9,375	1.00	
	TOTALS		0	9,375		
500.00	Grand Total: Increases		76,752	148,135	500.00	

RECLASSIFICATIONS

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet A-6

Date/Time Prepared:  
9/3/2016 10:00 am

		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	<b>A - RECLASSIFY CAFETERIA COSTS</b>							
1.00	DIETARY	10.00	20,055	12,349	0		1.00	
	TOTALS		20,055	12,349				
	<b>B - RECLASS SOCIAL SERVICE COST</b>							
1.00	ADULTS & PEDIATRICS	30.00	4,616	0	0		1.00	
	TOTALS		4,616	0				
	<b>C - RECLASS PROFESSIONAL LIABILITY INSUR</b>							
1.00	RURAL HEALTH CLINIC	88.00	0	35,285	0		1.00	
	TOTALS		0	35,285				
	<b>D - RECLASSIFY XRAY DIRECTORS SALARY</b>							
1.00	INFORMATION SYSTEMS	5.01	52,081	0	0		1.00	
	TOTALS		52,081	0				
	<b>E - RECLASSIFY ANESTHESIA PRO FEES</b>							
1.00	ANESTHESIOLOGY	53.00	0	14,800	0		1.00	
	TOTALS		0	14,800				
	<b>F - INTEREST EXPENSE</b>							
1.00	INTEREST EXPENSE	113.00	0	63,579	9		1.00	
	TOTALS		0	63,579				
	<b>G - TO RECLASS INTEROCULAR LENS</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,132	0		1.00	
	TOTALS		0	10,132				
	<b>H - TO RECLASS ANNEX BLDG DEPRECIATION</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,615	9		1.00	
	TOTALS		0	2,615				
	<b>J - TO RCLS PHYS RECRUIT EXP FOR CLINIC</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	9,375	0		1.00	
	TOTALS		0	9,375				
500.00	Grand Total: Decreases		76,752	148,135			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet A-7  
Part I  
Date/Time Prepared:  
9/3/2016 10:00 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	62,855	0	0	0	1.00
2.00	Land Improvements	401,647	17,383	0	17,383	2.00
3.00	Buildings and Fixtures	9,435,838	36,006	0	36,006	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	5,408,763	12,816	0	12,816	6.00
7.00	HIT designated Assets	927,041	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,236,144	66,205	0	66,205	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	16,236,144	66,205	0	66,205	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	62,855	0			1.00
2.00	Land Improvements	419,030	0			2.00
3.00	Buildings and Fixtures	9,460,894	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	5,421,579	0			6.00
7.00	HIT designated Assets	927,041	0			7.00
8.00	Subtotal (sum of lines 1-7)	16,291,399	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	16,291,399	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet A-7  
Part II  
Date/Time Prepared:  
9/3/2016 10:00 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	277,468	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	311,260	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	588,728	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	277,468				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	311,260				2.00
3.00	Total (sum of lines 1-2)	0	588,728				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet A-7  
Part III  
Date/Time Prepared:  
9/3/2016 10:00 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	9,942,779	0	9,942,779	0.610308	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,348,620	0	6,348,620	0.389692	0	2.00
3.00	Total (sum of lines 1-2)	16,291,399	0	16,291,399	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	338,432	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	219,458	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	557,890	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	338,432	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	219,458	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	557,890	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet A-8

Date/Time Prepared:  
9/3/2016 10:00 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)	B	-13,086	0	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-608	0	CENTRAL SERVICES & SUPPLY	14.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0	0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0	0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0	0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0	0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0	0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-225,367	0			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-34	0	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0	0			0	12.00
13.00 Laundry and linen service		0	0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-14,084	0	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others		0	0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0	0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0	0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-2,125	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0	0		0.00	0	19.00
20.00 Vending machines		0	0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0	0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0	0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	0	NONPHYSICIAN ANESTHETISTS	19.00	0	28.00
29.00 Physicians' assistant		0	0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-91,770	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00 MISCELLANEOUS REVENUE - FLU SHOTS	B	-750	0	DRUGS CHARGED TO PATIENTS	73.00	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	
33.01 MISCELLANEOUS REVENUE - OTHER	B	-600	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 33.01
34.00 LAB FEES	A	-1,036	LABORATORY	60.00	0 34.00
35.00 EDUCATION FEES	B	-750	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 35.00
36.00 NONALLOWABLE PUBLIC RELATIONS	A	-25,372	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 36.00
37.00 HEALTHLINK ADMIN FEES	A	27,924	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 37.00
38.00 LOBBYING PORTION OF DUES	A	-15,668	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 38.00
39.00 NON-RHC SERVICES	A	-104,752	RURAL HEALTH CLINIC	88.00	0 39.00
40.00 NON-RHC BENEFITS	A	-9,842	RURAL HEALTH CLINIC	88.00	0 40.00
41.00 TELEPHONE SERVICE	B	-7,437	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 41.00
42.00 NON-RHC DEPRECIATION	A	-32	CAP REL COSTS-MVBLE EQUIP	2.00	9 42.00
43.00 340B PHARMACY	A	-115,788	DRUGS CHARGED TO PATIENTS	73.00	0 43.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-601,177			50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet A-8-2

Date/Time Prepared:  
9/3/2016 10:00 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	54.00 RADIOLOGY-DIAGNOSTIC	6,369	6,369	0	0	0
2.00	60.00 LABORATORY	18,363	0	18,363	0	0
3.00	69.00 ELECTROCARDIOLOGY	13,234	13,234	0	0	0
4.00	91.00 EMERGENCY	1,203,630	205,653	997,977	0	0
5.00	65.00 RESPIRATORY THERAPY	111	111	0	0	0
6.00	0.00	0	0	0	0	0
7.00	0.00	0	0	0	0	0
8.00	0.00	0	0	0	0	0
9.00	0.00	0	0	0	0	0
10.00	0.00	0	0	0	0	0
200.00		1,241,707	225,367	1,016,340		

Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance
1.00	2.00	8.00	9.00	12.00	13.00	14.00
1.00	54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
2.00	60.00 LABORATORY	0	0	0	0	0
3.00	69.00 ELECTROCARDIOLOGY	0	0	0	0	0
4.00	91.00 EMERGENCY	0	0	0	0	0
5.00	65.00 RESPIRATORY THERAPY	0	0	0	0	0
6.00	0.00	0	0	0	0	0
7.00	0.00	0	0	0	0	0
8.00	0.00	0	0	0	0	0
9.00	0.00	0	0	0	0	0
10.00	0.00	0	0	0	0	0
200.00		0	0	0	0	0

Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment
1.00	2.00	15.00	16.00	17.00	18.00
1.00	54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	6,369
2.00	60.00 LABORATORY	0	0	0	0
3.00	69.00 ELECTROCARDIOLOGY	0	0	0	13,234
4.00	91.00 EMERGENCY	0	0	0	205,653
5.00	65.00 RESPIRATORY THERAPY	0	0	0	111
6.00	0.00	0	0	0	0
7.00	0.00	0	0	0	0
8.00	0.00	0	0	0	0
9.00	0.00	0	0	0	0
10.00	0.00	0	0	0	0
200.00		0	0	0	225,367

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet B  
Part I  
Date/Time Prepared:  
9/3/2016 10:00 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	INFORMATION SYSTEMS	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	338,432	338,432			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	219,458		219,458		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,128,135	620	0	2,128,755	4.00
5.01 00550	INFORMATION SYSTEMS	512,252	4,519	10,279	63,974	591,024 5.01
5.02 00591	OTHER ADMINISTRATIVE AND GENERAL	1,273,156	72,028	10,077	241,803	105,377 5.02
6.00 00600	MAINTENANCE & REPAIRS	525,695	53,981	1,241	36,710	9,163 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	87,445	4,256	0	0	0 8.00
9.00 00900	HOUSEKEEPING	225,401	1,949	0	64,034	9,163 9.00
10.00 01000	DIETARY	345,264	7,985	589	68,186	13,745 10.00
11.00 01100	CAFETERIA	18,320	3,922	0	6,399	0 11.00
13.00 01300	NURSING ADMINISTRATION	84,931	620	0	27,037	4,582 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	71,975	3,570	6,330	17,520	9,163 14.00
15.00 01500	PHARMACY	139,574	4,368	2,973	38,322	18,326 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	225,504	4,575	78	59,925	27,489 16.00
17.00 01700	SOCIAL SERVICE	4,616	413	0	1,473	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	218,888	0	0	65,124	0 19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	601,392	30,128	6,613	182,285	54,979 30.00
46.00 04600	OTHER LONG TERM CARE	566,792	42,891	458	172,122	18,326 46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	244,098	15,872	41,464	44,453	22,908 50.00
53.00 05300	ANESTHESIOLOGY	22,129	0	2,480	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	649,127	21,025	108,583	112,978	54,979 54.00
60.00 06000	LABORATORY	908,610	9,479	1,463	119,856	22,908 60.00
65.00 06500	RESPIRATORY THERAPY	91,789	2,236	2,989	8,918	0 65.00
66.00 06600	PHYSICAL THERAPY	828,248	9,268	6,259	250,313	73,305 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
68.01 06801	CARDIAC REHAB	54,685	1,978	6,844	16,199	4,582 68.01
69.00 06900	ELECTROCARDIOLOGY	4,877	272	1,792	1,556	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,487	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	10,132	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	644,537	0	0	0	0 73.00
76.00 03480	ONCOLOGY	5,761	1,113	4	1,776	4,582 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	1,360,702	11,325	73	391,582	87,050 88.00
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	1,445,761	16,187	6,703	136,056	27,489 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
93.00 04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0 93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					0 113.00
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0 115.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	13,915,173	324,580	217,292	2,128,601	568,116 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,709	0	0	0	0 190.00
190.01 19001	OUTPATIENT CLINIC	797	13,852	2,166	154	22,908 190.01
190.02 19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0 190.02
191.00 19100	RESEARCH	0	0	0	0	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers					0 201.00
202.00	TOTAL (sum lines 118-201)	13,922,679	338,432	219,458	2,128,755	591,024 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet B  
Part I  
Date/Time Prepared:  
9/3/2016 10:00 am

Cost Center Description		Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5A.01	5.02	6.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00591	1,702,441	1,702,441				5.02
6.00	00600	626,790	87,320	714,110			6.00
8.00	00800	91,701	12,775	14,661	119,137		8.00
9.00	00900	300,547	41,870	6,716	0	349,133	9.00
10.00	01000	435,769	60,708	27,510	0	13,865	10.00
11.00	01100	28,641	3,990	13,512	0	6,810	11.00
13.00	01300	117,170	16,323	2,136	0	1,077	13.00
14.00	01400	108,558	15,124	12,299	0	6,198	14.00
15.00	01500	203,563	28,359	15,050	0	7,585	15.00
16.00	01600	317,571	44,242	15,762	0	7,944	16.00
17.00	01700	6,502	906	1,424	0	718	17.00
19.00	01900	284,012	39,567	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	875,397	121,954	103,793	12,736	52,311	30.00
46.00	04600	800,589	111,532	147,759	84,242	74,471	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	368,795	51,378	54,680	2,560	27,558	50.00
53.00	05300	24,609	3,428	0	0	0	53.00
54.00	05400	946,692	131,887	72,432	3,782	36,505	54.00
60.00	06000	1,062,316	147,994	32,656	0	16,458	60.00
65.00	06500	105,932	14,758	7,703	106	3,882	65.00
66.00	06600	1,167,393	162,633	31,928	9,838	16,091	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
68.01	06801	84,288	11,742	6,813	0	3,434	68.01
69.00	06900	8,497	1,184	939	0	473	69.00
71.00	07100	57,487	8,009	0	0	0	71.00
72.00	07200	10,132	1,412	0	0	0	72.00
73.00	07300	644,537	89,792	0	0	0	73.00
76.00	03480	13,236	1,844	3,835	10	1,933	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	1,850,732	257,834	39,016	167	19,664	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	1,632,196	227,386	55,764	5,159	28,105	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04950	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	0	0	0	0	113.00
115.00	11500	0	0	0	0	0	115.00
118.00		13,876,093	1,695,951	666,388	118,600	325,082	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	6,709	935	0	0	0	190.00
190.01	19001	39,877	5,555	47,722	537	24,051	190.01
190.02	19003	0	0	0	0	0	190.02
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		13,922,679	1,702,441	714,110	119,137	349,133	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet B  
Part I  
Date/Time Prepared:  
9/3/2016 10:00 am

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00591						5.02
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	537,852					10.00
11.00	01100	0	52,953				11.00
13.00	01300	0	580	137,286			13.00
14.00	01400	0	961	0	143,140		14.00
15.00	01500	0	597	0	358	255,512	15.00
16.00	01600	0	2,899	0	105	0	16.00
17.00	01700	0	59	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	106,376	7,163	43,786	34,699	155	30.00
46.00	04600	428,752	9,939	0	21,151	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	1,605	10,811	11,380	48	50.00
53.00	05300	0	603	0	2,907	0	53.00
54.00	05400	0	3,461	0	1,872	220	54.00
60.00	06000	0	4,369	0	5,563	39	60.00
65.00	06500	0	469	2,665	682	0	65.00
66.00	06600	0	7,304	0	2,279	462	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
68.01	06801	0	0	0	1,204	0	68.01
69.00	06900	0	662	0	64	0	69.00
71.00	07100	0	0	0	26,791	0	71.00
72.00	07200	0	0	0	14,010	0	72.00
73.00	07300	0	0	0	0	254,383	73.00
76.00	03480	0	64	0	239	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	7,298	47,381	4,361	76	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	4,914	32,643	15,257	129	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04950	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	0	0	0	0	113.00
115.00	11500	0	0	0	0	0	115.00
118.00		535,128	52,947	137,286	142,922	255,512	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	6	0	218	0	190.01
190.02	19003	2,724	0	0	0	0	190.02
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		537,852	52,953	137,286	143,140	255,512	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet B  
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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	17.00	19.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	INFORMATION SYSTEMS					5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	388,523				16.00
17.00	01700	SOCIAL SERVICE	0	9,609			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	323,579		19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	20,455	8,648	0	1,387,473	30.00
46.00	04600	OTHER LONG TERM CARE	21,923	961	0	1,701,319	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	29,319	0	0	558,134	50.00
53.00	05300	ANESTHESIOLOGY	2,319	0	323,579	357,445	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	102,548	0	0	1,299,399	54.00
60.00	06000	LABORATORY	74,383	0	0	1,343,778	60.00
65.00	06500	RESPIRATORY THERAPY	6,254	0	0	142,451	65.00
66.00	06600	PHYSICAL THERAPY	48,171	0	0	1,446,099	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	1,681	0	0	109,162	68.01
69.00	06900	ELECTROCARDIOLOGY	4,108	0	0	15,927	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,441	0	0	93,728	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	527	0	0	26,081	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,010	0	0	1,016,722	73.00
76.00	03480	ONCOLOGY	1,149	0	0	22,310	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	16,272	0	0	2,242,801	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	29,963	0	0	2,031,516	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	39,072	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	388,523	9,609	323,579	13,794,345	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7,644	190.00
190.01	19001	OUTPATIENT CLINIC	0	0	0	117,966	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	2,724	190.02
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	388,523	9,609	323,579	13,922,679	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet B  
Part I  
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9/3/2016 10:00 am

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00550 INFORMATION SYSTEMS		5.01
5.02	00591 OTHER ADMINISTRATIVE AND GENERAL		5.02
6.00	00600 MAINTENANCE & REPAIRS		6.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS	1,348,401	30.00
46.00	04600 OTHER LONG TERM CARE	1,701,319	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	558,134	50.00
53.00	05300 ANESTHESIOLOGY	357,445	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,299,399	54.00
60.00	06000 LABORATORY	1,343,778	60.00
65.00	06500 RESPIRATORY THERAPY	142,451	65.00
66.00	06600 PHYSICAL THERAPY	1,446,099	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	68.00
68.01	06801 CARDIAC REHAB	109,162	68.01
69.00	06900 ELECTROCARDIOLOGY	15,927	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	93,728	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	26,081	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,016,722	73.00
76.00	03480 ONCOLOGY	22,310	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800 RURAL HEALTH CLINIC	2,242,801	88.00
90.00	09000 CLINIC	0	90.00
91.00	09100 EMERGENCY	2,031,516	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	39,072	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
95.00	09500 AMBULANCE SERVICES	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300 INTEREST EXPENSE		113.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	115.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	13,794,345	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,644	190.00
190.01	19001 OUTPATIENT CLINIC	117,966	190.01
190.02	19003 NON-REIMBURSEABLE OUTPATIENT MEALS	2,724	190.02
191.00	19100 RESEARCH	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300 NONPAID WORKERS	0	193.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	13,922,679	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet B  
Part II  
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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			
<b>GENERAL SERVICE COST CENTERS</b>						
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	620	0	620	4.00
5.01 00550	INFORMATION SYSTEMS	0	4,519	10,279	14,798	5.01
5.02 00591	OTHER ADMINISTRATIVE AND GENERAL	0	72,028	10,077	82,105	5.02
6.00 00600	MAINTENANCE & REPAIRS	0	53,981	1,241	55,222	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	4,256	0	4,256	8.00
9.00 00900	HOUSEKEEPING	0	1,949	0	1,949	9.00
10.00 01000	DIETARY	0	7,985	589	8,574	10.00
11.00 01100	CAFETERIA	0	3,922	0	3,922	11.00
13.00 01300	NURSING ADMINISTRATION	0	620	0	620	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	3,570	6,330	9,900	14.00
15.00 01500	PHARMACY	0	4,368	2,973	7,341	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	4,575	78	4,653	16.00
17.00 01700	SOCIAL SERVICE	0	413	0	413	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	30,128	6,613	36,741	30.00
46.00 04600	OTHER LONG TERM CARE	0	42,891	458	43,349	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	15,872	41,464	57,336	50.00
53.00 05300	ANESTHESIOLOGY	0	0	2,480	2,480	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	21,025	108,583	129,608	54.00
60.00 06000	LABORATORY	0	9,479	1,463	10,942	60.00
65.00 06500	RESPIRATORY THERAPY	0	2,236	2,989	5,225	65.00
66.00 06600	PHYSICAL THERAPY	0	9,268	6,259	15,527	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
68.01 06801	CARDIAC REHAB	0	1,978	6,844	8,822	68.01
69.00 06900	ELECTROCARDIOLOGY	0	272	1,792	2,064	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
76.00 03480	ONCOLOGY	0	1,113	4	1,117	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	11,325	73	11,398	88.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	16,187	6,703	22,890	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	324,580	217,292	541,872	620 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01 19001	OUTPATIENT CLINIC	0	13,852	2,166	16,018	190.01
190.02 19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	190.02
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	338,432	219,458	557,890	620 202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 141308		Period: From 05/01/2015 To 04/30/2016		Worksheet B Part II Date/Time Prepared: 9/3/2016 10:00 am	
Cost Center Description			INFORMATION SYSTEMS	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	6.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS	14,817					5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	2,643	84,818				5.02
6.00	00600	MAINTENANCE & REPAIRS	230	4,351	59,814			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	636	1,228	6,120		8.00
9.00	00900	HOUSEKEEPING	230	2,086	563	0	4,847	9.00
10.00	01000	DIETARY	345	3,025	2,304	0	192	10.00
11.00	01100	CAFETERIA	0	199	1,132	0	95	11.00
13.00	01300	NURSING ADMINISTRATION	115	813	179	0	15	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	230	754	1,030	0	86	14.00
15.00	01500	PHARMACY	459	1,413	1,261	0	105	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	689	2,204	1,320	0	110	16.00
17.00	01700	SOCIAL SERVICE	0	45	119	0	10	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	1,971	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,378	6,076	8,694	654	726	30.00
46.00	04600	OTHER LONG TERM CARE	459	5,557	12,376	4,328	1,034	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	574	2,560	4,580	132	383	50.00
53.00	05300	ANESTHESIOLOGY	0	171	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,378	6,571	6,067	194	507	54.00
60.00	06000	LABORATORY	574	7,374	2,735	0	228	60.00
65.00	06500	RESPIRATORY THERAPY	0	735	645	5	54	65.00
66.00	06600	PHYSICAL THERAPY	1,838	8,103	2,674	505	223	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
68.01	06801	CARDIAC REHAB	115	585	571	0	48	68.01
69.00	06900	ELECTROCARDIOLOGY	0	59	79	0	7	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	399	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	70	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,474	0	0	0	73.00
76.00	03480	ONCOLOGY	115	92	321	0	27	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	2,182	12,842	3,268	9	273	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	689	11,329	4,671	265	390	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,243	84,494	55,817	6,092	4,513	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	47	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	574	277	3,997	28	334	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,817	84,818	59,814	6,120	4,847	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141308		Period: From 05/01/2015 To 04/30/2016		Worksheet B Part II Date/Time Prepared: 9/3/2016 10:00 am	
Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00591						5.02
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	14,460					10.00
11.00	01100	0	5,350				11.00
13.00	01300	0	59	1,809			13.00
14.00	01400	0	97	0	12,102		14.00
15.00	01500	0	60	0	30	10,680	15.00
16.00	01600	0	293	0	9	0	16.00
17.00	01700	0	6	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,860	724	577	2,934	6	30.00
46.00	04600	11,527	1,004	0	1,788	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	162	142	962	2	50.00
53.00	05300	0	61	0	246	0	53.00
54.00	05400	0	350	0	158	9	54.00
60.00	06000	0	441	0	470	2	60.00
65.00	06500	0	47	35	58	0	65.00
66.00	06600	0	738	0	193	19	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
68.01	06801	0	0	0	102	0	68.01
69.00	06900	0	67	0	5	0	69.00
71.00	07100	0	0	0	2,265	0	71.00
72.00	07200	0	0	0	1,185	0	72.00
73.00	07300	0	0	0	0	10,634	73.00
76.00	03480	0	7	0	20	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	737	625	369	3	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	496	430	1,290	5	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04950	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	0	0	0	0	113.00
115.00	11500	0	0	0	0	0	115.00
118.00		14,387	5,349	1,809	12,084	10,680	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	1	0	18	0	190.01
190.02	19003	73	0	0	0	0	190.02
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		14,460	5,350	1,809	12,102	10,680	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	17.00	19.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	INFORMATION SYSTEMS					5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,295				16.00
17.00	01700	SOCIAL SERVICE	0	593			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	1,990		19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	490	534	62,447	0	30.00
46.00	04600	OTHER LONG TERM CARE	525	59	82,056	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	702	0	67,548	0	50.00
53.00	05300	ANESTHESIOLOGY	56	0	3,014	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,451	0	147,326	0	54.00
60.00	06000	LABORATORY	1,780	0	24,581	0	60.00
65.00	06500	RESPIRATORY THERAPY	150	0	6,957	0	65.00
66.00	06600	PHYSICAL THERAPY	1,153	0	31,046	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	40	0	10,288	0	68.01
69.00	06900	ELECTROCARDIOLOGY	98	0	2,379	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34	0	2,698	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13	0	1,268	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	670	0	15,778	0	73.00
76.00	03480	ONCOLOGY	27	0	1,727	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	389	0	32,208	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	717	0	43,212	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,295	593	0	534,533	0
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	47	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	0	21,247	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	73	0	190.02
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments			1,990	1,990	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	9,295	593	1,990	557,890	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

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Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00550	INFORMATION SYSTEMS	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	5.02
6.00	00600	MAINTENANCE & REPAIRS	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
46.00	04600	OTHER LONG TERM CARE	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
68.01	06801	CARDIAC REHAB	68.01
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03480	ONCOLOGY	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
95.00	09500	AMBULANCE SERVICES	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300	INTEREST EXPENSE	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
190.01	19001	OUTPATIENT CLINIC	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	190.02
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	INFORMATION SYSTEMS (# OF COMPUTERS)	Reconciliation	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	72,049				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		220,747			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	132	0	6,671,207		4.00
5.01 00550	INFORMATION SYSTEMS	962	10,339	200,484	129	5.01
5.02 00591	OTHER ADMINISTRATIVE AND GENERAL	15,334	10,136	757,774	23	-1,702,441
6.00 00600	MAINTENANCE & REPAIRS	11,492	1,248	115,043	2	0
8.00 00800	LAUNDRY & LINEN SERVICE	906	0	0	0	0
9.00 00900	HOUSEKEEPING	415	0	200,672	2	0
10.00 01000	DIETARY	1,700	592	213,685	3	0
11.00 01100	CAFETERIA	835	0	20,055	0	0
13.00 01300	NURSING ADMINISTRATION	132	0	84,731	1	0
14.00 01400	CENTRAL SERVICES & SUPPLY	760	6,367	54,905	2	0
15.00 01500	PHARMACY	930	2,990	120,097	4	0
16.00 01600	MEDICAL RECORDS & LIBRARY	974	78	187,796	6	0
17.00 01700	SOCIAL SERVICE	88	0	4,616	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	204,088	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	6,414	6,652	571,255	12	0
46.00 04600	OTHER LONG TERM CARE	9,131	461	539,405	4	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	3,379	41,708	139,310	5	0
53.00 05300	ANESTHESIOLOGY	0	2,495	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,476	109,221	354,057	12	0
60.00 06000	LABORATORY	2,018	1,472	375,610	5	0
65.00 06500	RESPIRATORY THERAPY	476	3,007	27,949	0	0
66.00 06600	PHYSICAL THERAPY	1,973	6,296	784,444	16	0
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
68.01 06801	CARDIAC REHAB	421	6,884	50,766	1	0
69.00 06900	ELECTROCARDIOLOGY	58	1,803	4,877	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
76.00 03480	ONCOLOGY	237	4	5,565	1	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	2,411	73	1,227,160	19	0
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	3,446	6,742	426,380	6	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00 04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	69,100	218,568	6,670,724	124	-1,702,441
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01 19001	OUTPATIENT CLINIC	2,949	2,179	483	5	0
190.02 19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
193.00 19300	NONPAID WORKERS	0	0	0	0	0
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)	338,432	219,458	2,128,755	591,024	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	4.697248	0.994161	0.319096	4,581.581395	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			620	14,817	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000093	114.860465	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet B-1  
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Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)		
		5.02	6.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00550	INFORMATION SYSTEMS					5.01	
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	12,220,238				5.02	
6.00	00600	MAINTENANCE & REPAIRS	626,790	44,129			6.00	
8.00	00800	LAUNDRY & LINEN SERVICE	91,701	906	37,044		8.00	
9.00	00900	HOUSEKEEPING	300,547	415	0	42,808	9.00	
10.00	01000	DIETARY	435,769	1,700	0	1,700	36,925	10.00
11.00	01100	CAFETERIA	28,641	835	0	835	0	11.00
13.00	01300	NURSING ADMINISTRATION	117,170	132	0	132	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	108,558	760	0	760	0	14.00
15.00	01500	PHARMACY	203,563	930	0	930	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	317,571	974	0	974	0	16.00
17.00	01700	SOCIAL SERVICE	6,502	88	0	88	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	284,012	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	875,397	6,414	3,960	6,414	7,303	30.00
46.00	04600	OTHER LONG TERM CARE	800,589	9,131	26,194	9,131	29,435	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	368,795	3,379	796	3,379	0	50.00
53.00	05300	ANESTHESIOLOGY	24,609	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	946,692	4,476	1,176	4,476	0	54.00
60.00	06000	LABORATORY	1,062,316	2,018	0	2,018	0	60.00
65.00	06500	RESPIRATORY THERAPY	105,932	476	33	476	0	65.00
66.00	06600	PHYSICAL THERAPY	1,167,393	1,973	3,059	1,973	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
68.01	06801	CARDIAC REHAB	84,288	421	0	421	0	68.01
69.00	06900	ELECTROCARDIOLOGY	8,497	58	0	58	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,487	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,132	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	644,537	0	0	0	0	73.00
76.00	03480	ONCOLOGY	13,236	237	3	237	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	1,850,732	2,411	52	2,411	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,632,196	3,446	1,604	3,446	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,173,652	41,180	36,877	39,859	36,738	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,709	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	39,877	2,949	167	2,949	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	187	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,702,441	714,110	119,137	349,133	537,852	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.139313	16.182329	3.216094	8.155789	14.566066	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	84,818	59,814	6,120	4,847	14,460	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006941	1.355435	0.165209	0.113226	0.391605	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

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Cost Center Description		CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00591						5.02
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	9,041					11.00
13.00	01300	99	67,631				13.00
14.00	01400	164	0	103,517			14.00
15.00	01500	102	0	259	648,152		15.00
16.00	01600	495	0	76	0	20,574,218	16.00
17.00	01700	10	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,223	21,570	25,093	394	1,083,196	30.00
46.00	04600	1,697	0	15,296	0	1,160,955	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	274	5,326	8,230	121	1,552,590	50.00
53.00	05300	103	0	2,102	0	122,789	53.00
54.00	05400	591	0	1,354	558	5,430,553	54.00
60.00	06000	746	0	4,023	100	3,938,920	60.00
65.00	06500	80	1,313	493	0	331,182	65.00
66.00	06600	1,247	0	1,648	1,173	2,550,879	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
68.01	06801	0	0	871	0	89,002	68.01
69.00	06900	113	0	46	0	217,514	69.00
71.00	07100	0	0	19,375	0	76,282	71.00
72.00	07200	0	0	10,132	0	27,881	72.00
73.00	07300	0	0	0	645,287	1,483,245	73.00
76.00	03480	11	0	173	0	60,826	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	1,246	23,341	3,154	193	861,692	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	839	16,081	11,034	326	1,586,712	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04950	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
115.00	11500	0	0	0	0	0	115.00
118.00		9,040	67,631	103,359	648,152	20,574,218	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	1	0	158	0	0	190.01
190.02	19003	0	0	0	0	0	190.02
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
200.00							200.00
201.00							201.00
202.00		52,953	137,286	143,140	255,512	388,523	202.00
203.00		5.856985	2.029927	1.382768	0.394216	0.018884	203.00
204.00		5,350	1,809	12,102	10,680	9,295	204.00
205.00		0.591749	0.026748	0.116908	0.016478	0.000452	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet B-1  
Date/Time Prepared:  
9/3/2016 10:00 am

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		17.00	19.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100			1.00
2.00	00200			2.00
4.00	00400			4.00
5.01	00550			5.01
5.02	00591			5.02
6.00	00600			6.00
8.00	00800			8.00
9.00	00900			9.00
10.00	01000			10.00
11.00	01100			11.00
13.00	01300			13.00
14.00	01400			14.00
15.00	01500			15.00
16.00	01600			16.00
17.00	01700	100		17.00
19.00	01900	0	100	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	90	0	30.00
46.00	04600	10	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	0	0	50.00
53.00	05300	0	100	53.00
54.00	05400	0	0	54.00
60.00	06000	0	0	60.00
65.00	06500	0	0	65.00
66.00	06600	0	0	66.00
67.00	06700	0	0	67.00
68.00	06800	0	0	68.00
68.01	06801	0	0	68.01
69.00	06900	0	0	69.00
71.00	07100	0	0	71.00
72.00	07200	0	0	72.00
73.00	07300	0	0	73.00
76.00	03480	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800	0	0	88.00
90.00	09000	0	0	90.00
91.00	09100	0	0	91.00
92.00	09200	0	0	92.00
93.00	04950	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500	0	0	95.00
98.00	09850	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300			113.00
115.00	11500	0	0	115.00
118.00		100	100	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	0	0	190.00
190.01	19001	0	0	190.01
190.02	19003	0	0	190.02
191.00	19100	0	0	191.00
192.00	19200	0	0	192.00
193.00	19300	0	0	193.00
200.00				200.00
201.00				201.00
202.00		9,609	323,579	202.00
203.00		96.090000	3,235.790000	203.00
204.00		593	1,990	204.00
205.00		5.930000	19.900000	205.00

Provider CCN: 141308

Period:  
 From 05/01/2015  
 To 04/30/2016

Worksheet B-2  
 Date/Time Prepared:  
 9/3/2016 10:00 am

	Description	Worksheet		Amount	
		Part	Line No.		
	1.00	2.00	3.00	4.00	
1.00	ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00	ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00	ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00	ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00	ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00	ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00	ADULTS AND PEDIATRICS	1	30.00	-39,072	7.00
8.00	OTHER OUTPATIENT SERVICES	1	93.00	39,072	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet C  
Part I  
Date/Time Prepared:  
9/3/2016 10:00 am

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	1,348,401	1,348,401	0	0	30.00
46.00	04600 OTHER LONG TERM CARE	1,701,319	1,701,319	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	558,134	558,134	0	0	50.00
53.00	05300 ANESTHESIOLOGY	357,445	357,445	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,299,399	1,299,399	0	0	54.00
60.00	06000 LABORATORY	1,343,778	1,343,778	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	142,451	142,451	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,446,099	1,446,099	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
68.01	06801 CARDIAC REHAB	109,162	109,162	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	15,927	15,927	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	93,728	93,728	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	26,081	26,081	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,016,722	1,016,722	0	0	73.00
76.00	03480 ONCOLOGY	22,310	22,310	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	2,242,801	2,242,801	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	90.00
91.00	09100 EMERGENCY	2,031,516	2,031,516	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	16,968	16,968	0	0	92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	39,072	39,072	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0	115.00
200.00	Subtotal (see instructions)	13,811,313	13,811,313	0	0	200.00
201.00	Less Observation Beds	16,968	16,968		0	201.00
202.00	Total (see instructions)	13,794,345	13,794,345	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet C  
Part I  
Date/Time Prepared:  
9/3/2016 10:00 am

		Title XVIII			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				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	650,646		650,646		30.00
46.00	04600	OTHER LONG TERM CARE	1,160,955		1,160,955		46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	3,875	1,548,715	1,552,590	0.359486	50.00
53.00	05300	ANESTHESIOLOGY	2,988	119,801	122,789	2.911051	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,244	5,363,309	5,430,553	0.239276	54.00
60.00	06000	LABORATORY	191,771	3,747,149	3,938,920	0.341154	60.00
65.00	06500	RESPIRATORY THERAPY	157,682	173,500	331,182	0.430129	65.00
66.00	06600	PHYSICAL THERAPY	477,375	2,073,504	2,550,879	0.566902	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
68.01	06801	CARDIAC REHAB	0	89,002	89,002	1.226512	68.01
69.00	06900	ELECTROCARDIOLOGY	5,882	211,632	217,514	0.073223	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,847	65,435	76,282	1.228704	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,881	27,881	0.935440	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	253,138	1,230,107	1,483,245	0.685471	73.00
76.00	03480	ONCOLOGY	0	60,826	60,826	0.366784	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	861,692	861,692		88.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	1,500	1,585,212	1,586,712	1.280331	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	20,538	20,538	0.826176	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	6,411	405,601	412,012	0.094832	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		115.00
200.00		Subtotal (see instructions)	2,990,314	17,583,904	20,574,218		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	2,990,314	17,583,904	20,574,218		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141308	Period: From 05/01/2015 To 04/30/2016	Worksheet C Part I Date/Time Prepared: 9/3/2016 10:00 am
		Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
46.00	04600 OTHER LONG TERM CARE			46.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
68.01	06801 CARDIAC REHAB	0.000000		68.01
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03480 ONCOLOGY	0.000000		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC			88.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)			115.00
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: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet C  
Part I  
Date/Time Prepared:  
9/3/2016 10:00 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		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		1,348,401	0	1,348,401	30.00	
46.00	04600 OTHER LONG TERM CARE		1,701,319	0	1,701,319	46.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM		558,134	0	558,134	50.00	
53.00	05300 ANESTHESIOLOGY		357,445	0	357,445	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,299,399	0	1,299,399	54.00	
60.00	06000 LABORATORY		1,343,778	0	1,343,778	60.00	
65.00	06500 RESPIRATORY THERAPY	0	142,451	0	142,451	65.00	
66.00	06600 PHYSICAL THERAPY	0	1,446,099	0	1,446,099	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00	
68.01	06801 CARDIAC REHAB	0	109,162	0	109,162	68.01	
69.00	06900 ELECTROCARDIOLOGY		15,927	0	15,927	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		93,728	0	93,728	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		26,081	0	26,081	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		1,016,722	0	1,016,722	73.00	
76.00	03480 ONCOLOGY		22,310	0	22,310	76.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC		2,242,801	0	2,242,801	88.00	
90.00	09000 CLINIC		0	0	0	90.00	
91.00	09100 EMERGENCY		2,031,516	0	2,031,516	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		16,968	0	16,968	92.00	
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER		39,072	0	39,072	93.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES		0	0	0	95.00	
98.00	09850 OTHER REIMBURSABLE COST CENTERS		0	0	0	98.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE					113.00	
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)		0	0	0	115.00	
200.00	Subtotal (see instructions)		13,811,313	0	13,811,313	200.00	
201.00	Less Observation Beds		16,968		16,968	201.00	
202.00	Total (see instructions)		13,794,345	0	13,794,345	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet C  
Part I  
Date/Time Prepared:  
9/3/2016 10:00 am

		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				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	650,646		650,646		30.00
46.00	04600	OTHER LONG TERM CARE	1,160,955		1,160,955		46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	3,875	1,548,715	1,552,590	0.359486	50.00
53.00	05300	ANESTHESIOLOGY	2,988	119,801	122,789	2.911051	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,244	5,363,309	5,430,553	0.239276	54.00
60.00	06000	LABORATORY	191,771	3,747,149	3,938,920	0.341154	60.00
65.00	06500	RESPIRATORY THERAPY	157,682	173,500	331,182	0.430129	65.00
66.00	06600	PHYSICAL THERAPY	477,375	2,073,504	2,550,879	0.566902	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
68.01	06801	CARDIAC REHAB	0	89,002	89,002	1.226512	68.01
69.00	06900	ELECTROCARDIOLOGY	5,882	211,632	217,514	0.073223	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,847	65,435	76,282	1.228704	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,881	27,881	0.935440	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	253,138	1,230,107	1,483,245	0.685471	73.00
76.00	03480	ONCOLOGY	0	60,826	60,826	0.366784	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	861,692	861,692	2.602787	88.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	1,500	1,585,212	1,586,712	1.280331	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	20,538	20,538	0.826176	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	6,411	405,601	412,012	0.094832	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		115.00
200.00		Subtotal (see instructions)	2,990,314	17,583,904	20,574,218		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	2,990,314	17,583,904	20,574,218		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet C  
Part I  
Date/Time Prepared:  
9/3/2016 10:00 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
46.00	04600 OTHER LONG TERM CARE				46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
68.01	06801 CARDIAC REHAB	0.000000			68.01
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03480 ONCOLOGY	0.000000			76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.000000			93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000			98.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300 INTEREST EXPENSE				113.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)				115.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 141308	Period: From 05/01/2015 To 04/30/2016	Worksheet D Part II Date/Time Prepared: 9/3/2016 10:00 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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	67,548	1,552,590	0.043507	3,875	169	50.00
53.00	05300 ANESTHESIOLOGY	3,014	122,789	0.024546	1,488	37	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	147,326	5,430,553	0.027129	42,515	1,153	54.00
60.00	06000 LABORATORY	24,581	3,938,920	0.006241	56,029	350	60.00
65.00	06500 RESPIRATORY THERAPY	6,957	331,182	0.021007	28,736	604	65.00
66.00	06600 PHYSICAL THERAPY	31,046	2,550,879	0.012171	5,999	73	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
68.01	06801 CARDIAC REHAB	10,288	89,002	0.115593	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	2,379	217,514	0.010937	3,262	36	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,698	76,282	0.035369	1,828	65	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,268	27,881	0.045479	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	15,778	1,483,245	0.010637	26,308	280	73.00
76.00	03480 ONCOLOGY	1,727	60,826	0.028392	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	32,208	861,692	0.037378	0	0	88.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	43,212	1,586,712	0.027234	1,231	34	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	786	20,538	0.038271	0	0	92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0	412,012	0.000000	2,336	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50-199)	390,816	18,762,617		173,607	2,801	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet D  
Part IV  
Date/Time Prepared:  
9/3/2016 10:00 am

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col . 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	323,579	0	0	0	0	323,579	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
200.00		Total (lines 50-199)	323,579	0	0	0	0	323,579	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet D  
Part IV  
Date/Time Prepared:  
9/3/2016 10:00 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	1,552,590	0.000000	0.000000	3,875	50.00
53.00	05300	ANESTHESIOLOGY	0	122,789	2.635244	0.000000	1,488	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,430,553	0.000000	0.000000	42,515	54.00
60.00	06000	LABORATORY	0	3,938,920	0.000000	0.000000	56,029	60.00
65.00	06500	RESPIRATORY THERAPY	0	331,182	0.000000	0.000000	28,736	65.00
66.00	06600	PHYSICAL THERAPY	0	2,550,879	0.000000	0.000000	5,999	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
68.01	06801	CARDIAC REHAB	0	89,002	0.000000	0.000000	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	217,514	0.000000	0.000000	3,262	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	76,282	0.000000	0.000000	1,828	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,881	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,483,245	0.000000	0.000000	26,308	73.00
76.00	03480	ONCOLOGY	0	60,826	0.000000	0.000000	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	861,692	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	1,586,712	0.000000	0.000000	1,231	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	20,538	0.000000	0.000000	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	412,012	0.000000	0.000000	2,336	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00		Total (lines 50-199)	0	18,762,617			173,607	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet D  
Part IV  
Date/Time Prepared:  
9/3/2016 10:00 am

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)	Cost
		11.00	12.00	13.00	
Title XVIII Hospital Cost					
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	3,921	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
68.01	06801 CARDIAC REHAB	0	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03480 ONCOLOGY	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES	0	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
200.00	Total (Lines 50-199)	3,921	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet D  
Part V  
Date/Time Prepared:  
9/3/2016 10:00 am

		Title XVIII		Hospital		Cost	
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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.359486	0	632,352	0	0	50.00
53.00	05300 ANESTHESIOLOGY	2.911051	0	50,910	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.239276	0	1,961,653	0	0	54.00
60.00	06000 LABORATORY	0.341154	0	1,555,852	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.430129	0	37,133	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.566902	0	718,833	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.01	06801 CARDIAC REHAB	1.226512	0	43,625	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	0.073223	0	93,019	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.228704	0	25,250	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.935440	0	17,531	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.685471	0	799,167	3,520	0	73.00
76.00	03480 ONCOLOGY	0.366784	0	54,763	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	1.280331	0	475,135	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.826176	0	6,860	0	0	92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.094832	0	171,275	2,691	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00	Subtotal (see instructions)		0	6,643,358	6,211	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	6,643,358	6,211	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet D  
Part V  
Date/Time Prepared:  
9/3/2016 10:00 am

		Title XVIII		Hospital	Cost
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			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	227,322	0	50.00
53.00	05300	ANESTHESIOLOGY	148,202	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	469,376	0	54.00
60.00	06000	LABORATORY	530,785	0	60.00
65.00	06500	RESPIRATORY THERAPY	15,972	0	65.00
66.00	06600	PHYSICAL THERAPY	407,508	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
68.01	06801	CARDIAC REHAB	53,507	0	68.01
69.00	06900	ELECTROCARDIOLOGY	6,811	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,025	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,399	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	547,806	2,413	73.00
76.00	03480	ONCOLOGY	20,086	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	608,330	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,668	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	16,242	255	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00		Subtotal (see instructions)	3,105,039	2,668	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	3,105,039	2,668	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141308

Period: From 05/01/2015

Worksheet D

Component CCN: 14Z308

To 04/30/2016

Part V  
Date/Time Prepared:  
9/3/2016 10:00 am

Title XVIII

Swing Beds - SNF

Cost

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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.359486	0	0	0	0	50.00
53.00 05300 ANESTHESIOLOGY	2.911051	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.239276	0	0	0	0	54.00
60.00 06000 LABORATORY	0.341154	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.430129	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.566902	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.01 06801 CARDIAC REHAB	1.226512	0	0	0	0	68.01
69.00 06900 ELECTROCARDIOLOGY	0.073223	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.228704	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.935440	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.685471	0	0	0	0	73.00
76.00 03480 ONCOLOGY	0.366784	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
91.00 09100 EMERGENCY	1.280331	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.826176	0	0	0	0	92.00
93.00 04950 OTHER OUTPATIENT SERVICE COST CENTER	0.094832	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00	Subtotal (see instructions)	0	0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141308

Period:

Worksheet D

Component CCN: 14Z308

From 05/01/2015  
To 04/30/2016

Part V  
Date/Time Prepared:  
9/3/2016 10:00 am

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
68.01	06801	CARDIAC REHAB	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03480	ONCOLOGY	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141308	Period: From 05/01/2015 To 04/30/2016	Worksheet D-1 Date/Time Prepared: 9/3/2016 10:00 am
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,961	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		244	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)		221	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,034	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)		517	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		132	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)		34	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		178	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)		979	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)		489	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		144.67	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		147.50	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,348,401	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)		19,096	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)		5,015	25.00
26.00	Total swing-bed cost (see instructions)		1,168,392	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		180,009	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		180,009	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		737.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		131,323	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)		131,323	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 141308	Period: From 05/01/2015 To 04/30/2016	Worksheet D-1 Date/Time Prepared: 9/3/2016 10:00 am			
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
Title XVIII			1.00	2.00	3.00	4.00	5.00	
Hospital								
Cost								
42.00	NURSERY (title V & XIX only)						42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT						43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description								
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						73,090	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						204,413	49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						722,277	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						360,770	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						1,083,047	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)						23	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						737.74	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						16,968	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141308		Period: From 05/01/2015 To 04/30/2016		Worksheet D-1 Date/Time Prepared: 9/3/2016 10:00 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)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	62,447	1,348,401	0.046312	16,968	786	90.00
91.00	Nursing School cost	0	1,348,401	0.000000	16,968	0	91.00
92.00	Allied health cost	0	1,348,401	0.000000	16,968	0	92.00
93.00	All other Medical Education	0	1,348,401	0.000000	16,968	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141308	Period: From 05/01/2015 To 04/30/2016	Worksheet D-3 Date/Time Prepared: 9/3/2016 10:00 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		149,750		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.359486	3,875	1,393	50.00
53.00	05300 ANESTHESIOLOGY	2.911051	1,488	4,332	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.239276	42,515	10,173	54.00
60.00	06000 LABORATORY	0.341154	56,029	19,115	60.00
65.00	06500 RESPIRATORY THERAPY	0.430129	28,736	12,360	65.00
66.00	06600 PHYSICAL THERAPY	0.566902	5,999	3,401	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
68.01	06801 CARDIAC REHAB	1.226512	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	0.073223	3,262	239	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.228704	1,828	2,246	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.935440	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.685471	26,308	18,033	73.00
76.00	03480 ONCOLOGY	0.366784	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	1.280331	1,231	1,576	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.826176	0	0	92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.094832	2,336	222	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		173,607	73,090	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		173,607		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141308	Period: From 05/01/2015 To 04/30/2016	Worksheet D-3	
		Component CCN: 14Z308		Date/Time Prepared: 9/3/2016 10:00 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS			0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.359486	0	0	50.00
53.00	05300 ANESTHESIOLOGY	2.911051	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.239276	16,787	4,017	54.00
60.00	06000 LABORATORY	0.341154	111,835	38,153	60.00
65.00	06500 RESPIRATORY THERAPY	0.430129	101,835	43,802	65.00
66.00	06600 PHYSICAL THERAPY	0.566902	431,948	244,872	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
68.01	06801 CARDIAC REHAB	1.226512	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	0.073223	2,249	165	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.228704	6,016	7,392	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.935440	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.685471	201,854	138,365	73.00
76.00	03480 ONCOLOGY	0.366784	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	1.280331	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.826176	0	0	92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.094832	3,443	327	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		875,967	477,093	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		875,967		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141308	Period: From 05/01/2015 To 04/30/2016	Worksheet E Part B Date/Time Prepared: 9/3/2016 10:00 am
		Title XVII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			3,107,707 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			3,107,707 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
<b>Customary charges</b>				
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)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			3,138,784 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			18,035 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,017,026 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)			2,103,723 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)			2,103,723 30.00
31.00	Primary payer payments			400 31.00
32.00	Subtotal (line 30 minus line 31)			2,103,323 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			95,856 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			62,306 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			95,856 36.00
37.00	Subtotal (see instructions)			2,165,629 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)			2,165,629 40.00
40.01	Sequestration adjustment (see instructions)			43,313 40.01
41.00	Interim payments			1,959,145 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			163,171 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet E-1  
Part I  
Date/Time Prepared:  
9/3/2016 10:00 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		130,003		1,624,483	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	12/21/2015	5,297	12/21/2015	11,733	3.01	
3.02		04/01/2016	4,983	04/01/2016	279,767	3.02	
3.03			0	04/30/2016	43,162	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)		10,280		334,662	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)		140,283		1,959,145	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		4,830		163,171	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		145,113		2,122,316	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: 141308  
Component CCN: 14Z308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet E-1  
Part I  
Date/Time Prepared:  
9/3/2016 10:00 am

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,302,977		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	12/21/2015	16,699		0	3.01
3.02		04/01/2016	66,178		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)		82,877		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,385,854		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		85,206		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,471,060		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: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet E-1  
Part II  
Date/Time Prepared:  
9/3/2016 10:00 am

		Title XVIII	Hospital	Cost
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			79 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			178 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			0 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			221 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			20,574,218 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			111,099 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
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
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: 141308

Period:

Worksheet E-2

Component CCN: 14Z308

From 05/01/2015  
To 04/30/2016

Date/Time Prepared:  
9/3/2016 10:00 am

		Title XVIII		Swing Beds - SNF	
		Part A	Part B	Cost	
		1.00	2.00		
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,093,877	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)	481,864	0	3.00	
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00	
5.00	Program days	1,468	0	5.00	
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00	
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00	
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,575,741	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	1,575,741	0	10.00	
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00	
12.00	Subtotal (line 10 minus line 11)	1,575,741	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	74,659	0	13.00	
14.00	80% of Part B costs (line 12 x 80%)		0	14.00	
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,501,082	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00	
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50	
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55	
17.00	Allowable bad debts (see instructions)	0	0	17.00	
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01	
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00	
19.00	Total (see instructions)	1,501,082	0	19.00	
19.01	Sequestration adjustment (see instructions)	30,022	0	19.01	
20.00	Interim payments	1,385,854	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)	85,206	0	22.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141308	Period: From 05/01/2015 To 04/30/2016	Worksheet E-3 Part V Date/Time Prepared: 9/3/2016 10:00 am
		Title XVIII	Hospital	Cost
		1.00		
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT</b>				
1.00	Inpatient services		204,413	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		204,413	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		206,457	6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
<b>Customary charges</b>				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		206,457	19.00
20.00	Deductibles (exclude professional component)		60,555	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		145,902	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		145,902	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		3,341	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		2,172	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,341	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		148,074	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (see instructions)		148,074	30.00
30.01	Sequestration adjustment (see instructions)		2,961	30.01
31.00	Interim payments		140,283	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)		4,830	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet G  
Date/Time Prepared:  
9/3/2016 10:00 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	647,625	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,093,228	0	0	0	4.00
5.00	Other receivable	77,104	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-350,000	0	0	0	6.00
7.00	Inventory	347,146	0	0	0	7.00
8.00	Prepaid expenses	97,878	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	2,912,981	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	62,855	0	0	0	12.00
13.00	Land improvements	419,030	0	0	0	13.00
14.00	Accumulated depreciation	-377,862	0	0	0	14.00
15.00	Buildings	9,460,894	0	0	0	15.00
16.00	Accumulated depreciation	-7,319,307	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,421,579	0	0	0	23.00
24.00	Accumulated depreciation	-4,788,304	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	927,041	0	0	0	27.00
28.00	Accumulated depreciation	-864,065	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)	2,941,861	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	1,265,643	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,265,643	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	7,120,485	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	207,103	0	0	0	37.00
38.00	Salaries, wages, and fees payable	627,557	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	264,254	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	0	0	0	0	43.00
44.00	Other current liabilities	277,864	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,376,778	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,367,808	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)	1,367,808	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,744,586	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	4,375,899				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	4,375,899	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	7,120,485	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet G-1

Date/Time Prepared:  
9/3/2016 10:00 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		5,005,265		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-629,366			2.00
3.00	Total (sum of line 1 and line 2)		4,375,899		0	3.00
4.00	Additions (credit adjustments) (specify)	0		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)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		4,375,899		0	11.00
12.00	Deductions (debit adjustments) (specify)	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)		4,375,899		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
9/3/2016 10:00 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	218,760		218,760	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	431,886		431,886	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	1,160,955		1,160,955	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,811,601		1,811,601	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,811,601		1,811,601	17.00
18.00	Ancillary services	1,165,427	17,449,355	18,614,782	18.00
19.00	Outpatient services	0	412,012	412,012	19.00
20.00	RURAL HEALTH CLINIC	0	1,187,105	1,187,105	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE				26.00
27.00	CHARITY CARE	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,977,028	19,048,472	22,025,500	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		14,523,856		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)		14,523,856		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141308

Period:  
From 05/01/2015  
To 04/30/2016

Worksheet G-3

Date/Time Prepared:  
9/3/2016 10:00 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	22,025,500	1.00
2.00	Less contractual allowances and discounts on patients' accounts	8,812,757	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,212,743	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,523,856	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,311,113	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	12,000	6.00
7.00	Income from investments	16,827	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	3,978	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	15,658	22.00
23.00	Governmental appropriations	372,037	23.00
24.00	GRANT INCOME	31,792	24.00
24.01	MEDICARE AND MEDICAID INCENTIVE REV	8,500	24.01
24.02	GAIN ON DISPOSAL OF FIXED ASSETS	163	24.02
24.03	OTHER MISCELLANEOUS INCOME	30,907	24.03
24.04	340B	189,885	24.04
25.00	Total other income (sum of lines 6-24)	681,747	25.00
26.00	Total (line 5 plus line 25)	-629,366	26.00
27.00	OTHER EXPENSES	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)	-629,366	29.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141308 Component CCN: 143472	Period: From 05/01/2015 To 04/30/2016	Worksheet M-1 Date/Time Prepared: 9/3/2016 10:00 am
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1.00	Physician	785,491	0	785,491	0	785,491	1.00
2.00	Physician Assistant	83,200	0	83,200	0	83,200	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	358,469	0	358,469	0	358,469	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,227,160	0	1,227,160	0	1,227,160	10.00
11.00	Physician Services Under Agreement	0	210,475	210,475	0	210,475	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	6,303	6,303	0	6,303	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	216,778	216,778	0	216,778	14.00
15.00	Medical Supplies	0	7,287	7,287	0	7,287	15.00
16.00	Transportation (Health Care Staff)	0	770	770	0	770	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	35,285	35,285	-35,285	0	18.00
19.00	Other Health Care Costs	0	0	0	9,375	9,375	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	43,342	43,342	-25,910	17,432	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,227,160	260,120	1,487,280	-25,910	1,461,370	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
<b>FACILITY OVERHEAD</b>							
29.00	Facility Costs	0	5,465	5,465	0	5,465	29.00
30.00	Administrative Costs	0	8,461	8,461	0	8,461	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	13,926	13,926	0	13,926	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,227,160	274,046	1,501,206	-25,910	1,475,296	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141308 Component CCN: 143472	Period: From 05/01/2015 To 04/30/2016	Worksheet M-1 Date/Time Prepared: 9/3/2016 10:00 am
		Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
	6.00	7.00		
<b>FACILITY HEALTH CARE STAFF COSTS</b>				
1.00	Physician	-52,379	733,112	1.00
2.00	Physician Assistant	0	83,200	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	358,469	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	-52,379	1,174,781	10.00
11.00	Physician Services Under Agreement	-62,215	148,260	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	6,303	13.00
14.00	Subtotal (sum of lines 11 through 13)	-62,215	154,563	14.00
15.00	Medical Supplies	0	7,287	15.00
16.00	Transportation (Health Care Staff)	0	770	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	9,375	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	17,432	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-114,594	1,346,776	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
<b>FACILITY OVERHEAD</b>				
29.00	Facility Costs	0	5,465	29.00
30.00	Administrative Costs	0	8,461	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	13,926	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-114,594	1,360,702	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141308	Period: From 05/01/2015 To 04/30/2016	Worksheet M-2
		Component CCN: 143472		Date/Time Prepared: 9/3/2016 10:00 am
			Rural Health Clinic (RHC) I	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>VISITS AND PRODUCTIVITY</b>						
<b>Positions</b>						
1.00	Physician	2.63	5,963	4,200	11,046	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.86	1,879	2,100	1,806	3.00
4.00	Subtotal (sum of lines 1 through 3)	3.49	7,842		12,852	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)	3.49	7,842		12,852	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	

<b>DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES</b>			
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,346,776	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,346,776	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)	13,926	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	882,099	15.00
16.00	Total overhead (sum of lines 14 and 15)	896,025	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtotal (see instructions)	896,025	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	896,025	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	2,242,801	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141308	Period: From 05/01/2015 To 04/30/2016	Worksheet M-3	
		Component CCN: 143472		Date/Time Prepared: 9/3/2016 10:00 am	
		Title XVIII	Rural Health Clinic (RHC) I	Cost	
				1.00	
<b>DETERMINATION OF RATE FOR RHC/FQHC SERVICES</b>					
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)			2,242,801	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			4,084	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,238,717	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			12,852	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)			12,852	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			174.19	7.00
			Calculation of Limit (1)		
			Prior to January 1	On or After January 1	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions)		174.19	174.19	9.00
<b>CALCULATION OF SETTLEMENT</b>					
10.00	Program covered visits excluding mental health services (from contractor records)		0	2,296	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	399,940	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			399,940	16.00
16.01	Total program charges (see instructions)(from contractor's records)			282,815	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			297,598	16.04
16.05	Total program cost (see instructions)			297,598	16.05
17.00	Primary payer amounts			143	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			27,942	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			50,926	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			297,455	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			855	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			298,310	22.00
23.00	Allowable bad debts (see instructions)			7,933	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			5,156	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			7,933	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)			303,466	26.00
26.01	Sequestration adjustment (see instructions)			6,069	26.01
27.00	Interim payments			306,575	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)			-9,178	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter I, §115.2			0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141308 Component CCN: 143472	Period: From 05/01/2015 To 04/30/2016	Worksheet M-4 Date/Time Prepared: 9/3/2016 10:00 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,174,781	1,174,781	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000074	0.000163	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	87	191	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,423	752	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,510	943	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,346,776	1,346,776	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	896,025	896,025	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001121	0.000700	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,004	627	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,514	1,570	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	21	46	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	119.71	34.13	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	4	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	718	137	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)		4,084	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)		855	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141308 Component CCN: 143472	Period: From 05/01/2015 To 04/30/2016	Worksheet M-5 Date/Time Prepared: 9/3/2016 10:00 am
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		306,575	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)		306,575	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		9,178	6.02
7.00	Total Medicare program liability (see instructions)		297,397	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00