

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: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/22/2016 2:49 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: 11/22/2016 Time: 2:49 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 FAIRFIELD MEMORIAL HOSPITAL ( 141311 ) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	26,610	-310,623	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	17,301	0	0	10.00
200.00 Total	0	26,610	-293,322	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/22/2016 2:48 pm
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	1.00	2.00	3.00	4.00							
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 303 NW 11TH STREET		PO Box:							1.00	
2.00	City: FAIRFIELD		State: IL		Zip Code: 62837		County: WAYNE				2.00
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
							V	XVIII	XIX		
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:											
3.00	Hospital	FAIRFIELD MEMORIAL HOSPITAL	141311	14999	1	04/01/2001	N	O	O	3.00	
4.00	Subprovider - IPF									4.00	
5.00	Subprovider - IRF									5.00	
6.00	Subprovider - (Other)									6.00	
7.00	Swing Beds - SNF									7.00	
8.00	Swing Beds - NF									8.00	
9.00	Hospital-Based SNF	FAIRFIELD MEMORIAL HOSPITAL	145552	14999		03/26/1985	N	P	N	9.00	
10.00	Hospital-Based NF									10.00	
11.00	Hospital-Based OLTC									11.00	
12.00	Hospital-Based HHA	FAIRFIELD MEMORIAL HOSPITAL HHA	147612	14999		05/01/1995	N	P	N	12.00	
13.00	Separately Certified ASC									13.00	
14.00	Hospital-Based Hospice									14.00	
15.00	Hospital-Based Health Clinic - RHC	FAIRFIELD RHC	148500	14999		03/13/2009	N	O	N	15.00	
16.00	Hospital-Based Health Clinic - FQHC									16.00	
17.00	Hospital-Based (CMHC) I									17.00	
18.00	Renal Dialysis									18.00	
19.00	Other									19.00	
						From:		To:			
						1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2015		06/30/2016		20.00	
21.00	Type of Control (see instructions)					2				21.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					N		N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N		N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N		N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N		N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							2		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.					0		0		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		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/22/2016 2:48 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		2			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		2			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0			35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.		0			37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)		N			37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N		N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N		N	40.00	
		V	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	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	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	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		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	
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))				
	1.00	2.00	3.00	4.00	5.00					
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
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)	N				106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	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	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0					118.00
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	0		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: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/22/2016 2:48 pm			
		1.00	2.00				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y			140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?		Y			144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.		N			145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N			146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N			147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N			148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N			149.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
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	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
				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: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/22/2016 2:48 pm	
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07/01/2015	06/30/2016	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: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/22/2016 2:48 pm		
			Y/N	Date		
			1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.						
COMPLETED BY ALL HOSPITALS						
Provider Organization and Operation						
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00	
			Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00	
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00	
			Y/N	Type	Date	
			1.00	2.00	3.00	
Financial Data and Reports						
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		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	08/26/2016	Y	08/26/2016	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/22/2016 2:48 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
<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		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
<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.		N		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.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
				1.00	2.00
<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.	RI CH	FERRI ELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923832	RFERRI ELL@ALLIANTMANAGEMENT.COM		43.00

		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.	REIMBURSEMENT MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141311

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/22/2016 2:48 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,686	51,384.00	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)		21	7,686	51,384.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,464	8,736.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,150	60,120.00	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	44.00	30	10,980		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		55				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: 141311

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/22/2016 2:48 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,435	242	2,141			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	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,435	242	2,141			7.00
8.00 INTENSIVE CARE UNIT	131	21	364			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		0	0			13.00
14.00 Total (see instructions)	1,566	263	2,505	0.00	191.36	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0	0	7,253	0.00	19.48	19.00
20.00 NURSING FACILITY		0	0	0.00	0.00	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	2,598	0	3,319	0.00	4.64	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	6,394	0	22,517	0.00	18.19	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	233.67	27.00
28.00 Observation Bed Days		0	893			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: 141311

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/22/2016 2:48 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	494	87	722	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	494	87	722	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	0.00					19.00
20.00 NURSING FACILITY	0.00					20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet S-3 Part IV Date/Time Prepared: 11/22/2016 2:48 pm
			Amount Reported	
			1.00	
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions		138,737	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		1,677,707	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		63,702	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		153,354	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		788,831	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		31,519	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	<b>Total Wage Related cost (Sum of lines 1 -23)</b>		<b>2,853,850</b>	<b>24.00</b>
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 141311 Component CCN: 147612		Period: From 07/01/2015 To 06/30/2016		Worksheet S-4 Date/Time Prepared: 11/22/2016 2:48 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County			WAYNE		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	123.00	0.00	30.00	153.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			14999			20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,250	278	42	1	1,571	21.00
22.00	Skilled Nursing Visit Charges	128,810	29,810	4,400	110	163,130	22.00
23.00	Physical Therapy Visits	732	37	14	7	790	23.00
24.00	Physical Therapy Visit Charges	78,430	4,070	1,100	770	84,370	24.00
25.00	Occupational Therapy Visits	210	0	1	0	211	25.00
26.00	Occupational Therapy Visit Charges	22,440	0	110	0	22,550	26.00
27.00	Speech Pathology Visits	25	0	0	0	25	27.00
28.00	Speech Pathology Visit Charges	2,875	0	0	0	2,875	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	1	0	0	0	1	31.00
32.00	Home Health Aide Visit Charges	62	0	0	0	62	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,218	315	57	8	2,598	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	232,617	33,880	5,610	880	272,987	35.00
36.00	Total Number of Episodes (standard/non outlier)	137		17	1	155	36.00
37.00	Total Number of Outlier Episodes		7		0	7	37.00
38.00	Total Non-Routine Medical Supply Charges	30,640	3,160	2,478	0	36,278	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141311

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

Worksheet S-7

Date/Time Prepared:  
11/22/2016 2:48 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00	
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	0	0	0	7.00
8.00	RHL	18	0	18	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	15	0	15	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	0	0	0	14.00
15.00	RVC	83	0	83	15.00
16.00	RVB	81	0	81	16.00
17.00	RVA	201	0	201	17.00
18.00	RHC	58	0	58	18.00
19.00	RHB	90	0	90	19.00
20.00	RHA	130	0	130	20.00
21.00	RMC	5	0	5	21.00
22.00	RMB	20	0	20	22.00
23.00	RMA	66	0	66	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	0	0	0	28.00
29.00	HE2	14	0	14	29.00
30.00	HE1	0	0	0	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	0	0	0	32.00
33.00	HC2	47	0	47	33.00
34.00	HC1	12	0	12	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	6	0	6	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	0	0	0	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	0	0	0	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	0	0	0	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	1	0	1	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	3	0	3	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	6	0	6	50.00
51.00	CB2	26	0	26	51.00
52.00	CB1	15	0	15	52.00
53.00	CA2	1	0	1	53.00
54.00	CA1	0	0	0	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141311

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

Worksheet S-7

Date/Time Prepared:  
11/22/2016 2:48 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		898	0	898	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).		14999	14999	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		1,035,520			207.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2015 To 06/30/2016	Worksheet S-8 Date/Time Prepared: 11/22/2016 2:48 pm Cost
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		1.00			
1.00	Clinic Address and Identification Street	303 NW 11TH STREET			1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	FAIRFIELD	IL	62837	2.00
		1.00			
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award	Date		
		1.00	2.00		
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)		0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)		0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		0		6.00
7.00	Appalachian Regional Commission		0		7.00
8.00	Look-Alikes		0		8.00
9.00	OTHER (SPECIFY)		0		9.00
		1.00			
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	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
11.00	Facility hours of operations (1) Clinic		09:00	05:00	09:00
		1.00			2.00
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N	0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	Provider name, CCN number	Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
					Total Visits
					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)				
		County			
		4.00			
2.00	City, State, ZIP Code, County	WAYNE			2.00
		Tuesday		Wednesday	Thursday
		to	from	to	from
		6.00	7.00	8.00	9.00
11.00	Facility hours of operations (1) Clinic	05:00	09:00	05:00	09:00
		05:00			11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2015 To 06/30/2016	Worksheet S-8 Date/Time Prepared: 11/22/2016 2:48 pm Cost
		Rural Health Clinic (RHC) I	

	Friday		Saturday		
	from	to	from	to	
	11.00	11.00	12.00	13.00	
11.00	Facility hours of operations (1) Clinic				11.00
	09:00	05:00			

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet S-10 Date/Time Prepared: 11/22/2016 2:48 pm
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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)		0.349125		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,798,829		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		3,036,919		5.00
6.00	Medicaid charges		15,636,818		6.00
7.00	Medicaid cost (line 1 times line 6)		5,459,204		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)		623,456		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0		9.00
10.00	Stand-alone SCHIP charges		0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		623,456		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	16,300	0	16,300	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	5,691	0	5,691	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	5,691	0	5,691	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)		3,307,364		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		528,125		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		2,779,239		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		970,302		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		975,993		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,599,449		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141311

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

Worksheet A  
Date/Time Prepared:  
11/22/2016 2:48 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		1,476,593	1,476,593	244,296	1,720,889	1.00
2.00	00200		0	0	631,068	631,068	2.00
4.00	00400				-1,388	2,972,216	4.00
5.00	00500	102,897	2,870,707	2,973,604	-85,752	3,456,227	5.00
6.00	00600	1,206,281	2,335,698	3,541,979	-9,542	630,666	6.00
7.00	00700	295,817	344,391	640,208	0	585,232	7.00
8.00	00800	0	585,232	585,232	0	412,136	8.00
9.00	00900	0	412,136	412,136	0	458,663	9.00
10.00	01000	317,352	141,311	458,663	-299,998	425,766	10.00
11.00	01100	348,133	377,631	725,764	245,848	245,848	11.00
13.00	01300	0	0	0	-37	247,047	13.00
16.00	01600	235,632	11,452	247,084	-9,845	329,438	16.00
17.00	01700	232,070	107,213	339,283	0	90,953	17.00
17.00	01700	83,626	7,327	90,953	0	90,953	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000						
30.00	03000	1,356,497	183,653	1,540,150	-6,372	1,533,778	30.00
31.00	03100	188,533	6,398	194,931	-1,803	193,128	31.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	674,009	55,053	729,062	-14,772	714,290	44.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,065,377	261,243	1,326,620	-70,740	1,255,880	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	489,242	1,146,056	1,635,298	-219,058	1,416,240	54.00
60.00	06000	754,446	1,260,233	2,014,679	-115,006	1,899,673	60.00
65.00	06500	159,665	156,791	316,456	-95,819	220,637	65.00
66.00	06600	731,057	16,505	747,562	-2,797	744,765	66.00
69.00	06900	0	0	0	84,270	84,270	69.00
71.00	07100	48,914	1,007,097	1,056,011	-113,972	942,039	71.00
72.00	07200	0	0	0	113,964	113,964	72.00
73.00	07300	219,759	1,274,195	1,493,954	-1,081	1,492,873	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	2,207,597	332,511	2,540,108	-18,179	2,521,929	88.00
90.00	09000	226,686	121,519	348,205	-1,955	346,250	90.00
90.01	09001	9,262	195,898	205,160	0	205,160	90.01
90.02	09002	68,795	131,113	199,908	0	199,908	90.02
91.00	09100	568,670	1,844,529	2,413,199	-5,281	2,407,918	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	248,426	65,572	313,998	-1,753	312,245	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300		372,344	372,344	-244,296	128,048	113.00
118.00		11,838,743	17,100,401	28,939,144	0	28,939,144	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	0	0	0	0	0	194.00
200.00		11,838,743	17,100,401	28,939,144	0	28,939,144	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141311

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

Worksheet A  
Date/Time Prepared:  
11/22/2016 2:48 pm

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	-451,732	1,269,157	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	631,068	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,972,216	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-813,555	2,642,672	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	630,666	6.00
7.00	00700	OPERATION OF PLANT	0	585,232	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	412,136	8.00
9.00	00900	HOUSEKEEPING	0	458,663	9.00
10.00	01000	DIETARY	0	425,766	10.00
11.00	01100	CAFETERIA	-174,507	71,341	11.00
13.00	01300	NURSING ADMINISTRATION	0	247,047	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-10,995	318,443	16.00
17.00	01700	SOCIAL SERVICE	0	90,953	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-295,781	1,237,997	30.00
31.00	03100	INTENSIVE CARE UNIT	0	193,128	31.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	714,290	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-491,063	764,817	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	-343	1,415,897	54.00
60.00	06000	LABORATORY	0	1,899,673	60.00
65.00	06500	RESPIRATORY THERAPY	0	220,637	65.00
66.00	06600	PHYSICAL THERAPY	0	744,765	66.00
69.00	06900	ELECTROCARDIOLOGY	-44,740	39,530	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	942,039	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	113,964	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-23,041	1,469,832	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	-141,704	2,380,225	88.00
90.00	09000	CLINIC	0	346,250	90.00
90.01	09001	WOUND CARE	0	205,160	90.01
90.02	09002	CLINIC	0	199,908	90.02
91.00	09100	EMERGENCY	-1,177,349	1,230,569	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	HOME HEALTH AGENCY	0	312,245	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	-128,048	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,752,858	25,186,286	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
194.00	07950	DR. OFFICE	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-3,752,858	25,186,286	200.00

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
<b>A - CAFETERIA</b>					
1.00	CAFETERIA	11.00	117,928	127,920	1.00
	TOTALS		117,928	127,920	
<b>C - EKG</b>					
1.00	ELECTROCARDIOLOGY	69.00	39,530	44,740	1.00
	TOTALS		39,530	44,740	
<b>D - RENTAL</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	631,068	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
	TOTALS		0	631,068	
<b>E - INTEREST</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	244,296	1.00
	TOTALS		0	244,296	
<b>F - IMPLANTABLE DEVICE</b>					
1.00	IMP. DEV CHARGED TO PATIENT	72.00	0	113,964	1.00
	TOTALS		0	113,964	
500.00	Grand Total: Increases		157,458	1,161,988	500.00

RECLASSIFICATIONS

Provider CCN: 141311

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

Worksheet A-6

Date/Time Prepared:  
11/22/2016 2:48 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - CAFETERIA</b>							
1.00	DIETARY	10.00	117,928	127,920	0		1.00
	TOTALS		117,928	127,920			
<b>C - EKG</b>							
1.00	RESPIRATORY THERAPY	65.00	39,530	44,740	0		1.00
	TOTALS		39,530	44,740			
<b>D - RENTAL</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,388	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	85,752	0		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	9,542	0		3.00
4.00	DIETARY	10.00	0	54,150	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	37	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	9,845	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	6,372	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	1,803	0		8.00
12.00	SKILLED NURSING FACILITY	44.00	0	14,772	0		12.00
13.00	OPERATING ROOM	50.00	0	70,740	0		13.00
14.00	RADIOLOGY - DIAGNOSTIC	54.00	0	219,058	0		14.00
15.00	LABORATORY	60.00	0	115,006	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	11,549	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	2,797	0		17.00
18.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	8	0		18.00
19.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,081	0		19.00
20.00	CLINIC	90.00	0	1,955	0		20.00
21.00	EMERGENCY	91.00	0	5,281	0		21.00
22.00	RURAL HEALTH CLINIC	88.00	0	18,179	0		22.00
23.00	HOME HEALTH AGENCY	101.00	0	1,753	0		23.00
	TOTALS		0	631,068			
<b>E - INTEREST</b>							
1.00	INTEREST EXPENSE	113.00	0	244,296	11		1.00
	TOTALS		0	244,296			
<b>F - IMPLANTABLE DEVICE</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	113,964	0		1.00
	TOTALS		0	113,964			
500.00	Grand Total: Decreases		157,458	1,161,988			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141311

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
11/22/2016 2:48 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	434,486	14,942	0	14,942	0 1.00
2.00	Land Improvements	640,428	0	0	0	0 2.00
3.00	Buildings and Fixtures	24,023,745	179,435	0	179,435	0 3.00
4.00	Building Improvements	0	0	0	0	0 4.00
5.00	Fixed Equipment	1,498,910	0	0	0	0 5.00
6.00	Movable Equipment	10,787,848	435,831	0	435,831	0 6.00
7.00	HIT designated Assets	0	0	0	0	0 7.00
8.00	Subtotal (sum of lines 1-7)	37,385,417	630,208	0	630,208	0 8.00
9.00	Reconciling Items	0	0	0	0	0 9.00
10.00	Total (line 8 minus line 9)	37,385,417	630,208	0	630,208	0 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	449,428	0			0 1.00
2.00	Land Improvements	640,428	0			0 2.00
3.00	Buildings and Fixtures	24,203,180	0			0 3.00
4.00	Building Improvements	0	0			0 4.00
5.00	Fixed Equipment	1,498,910	0			0 5.00
6.00	Movable Equipment	11,223,679	0			0 6.00
7.00	HIT designated Assets	0	0			0 7.00
8.00	Subtotal (sum of lines 1-7)	38,015,625	0			0 8.00
9.00	Reconciling Items	0	0			0 9.00
10.00	Total (line 8 minus line 9)	38,015,625	0			0 10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141311

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
11/22/2016 2:48 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,476,593	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,476,593	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	1,476,593				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,476,593				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141311

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
11/22/2016 2:48 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,476,593	0	1,476,593	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	1,476,593	0	1,476,593	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	1,024,861	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	631,068	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,655,929	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	244,296	0	0	0	1,269,157	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	631,068	2.00
3.00	Total (sum of lines 1-2)	244,296	0	0	0	1,900,225	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141311

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

Worksheet A-8

Date/Time Prepared:  
11/22/2016 2:48 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			3.00	4.00			
1.00							
2.00							
3.00							
4.00							
5.00							
1.00			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	B	-128,048		INTEREST EXPENSE	113.00	0	3.00
4.00		0			0.00	0	4.00
5.00		0			0.00	0	5.00
6.00		0			0.00	0	6.00
7.00	A	-6,105		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00		0			0.00	0	8.00
9.00		0			0.00	0	9.00
10.00	A-8-2	-2,008,933				0	10.00
11.00		0			0.00	0	11.00
12.00	A-8-1	-343				0	12.00
13.00		0			0.00	0	13.00
14.00	B	-174,507		CAFETERIA	11.00	0	14.00
15.00		0			0.00	0	15.00
16.00		0			0.00	0	16.00
17.00		0			0.00	0	17.00
18.00	B	-10,995		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00		0			0.00	0	19.00
20.00		0			0.00	0	20.00
21.00		0			0.00	0	21.00
22.00		0			0.00	0	22.00
23.00	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00			0	*** Cost Center Deleted ***	114.00		25.00
26.00			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00			0	*** Cost Center Deleted ***	19.00		28.00
29.00			0		0.00	0	29.00
30.00	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
30.99			0	ADULTS & PEDIATRICS	30.00		30.99
31.00	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00	A	-210,486		CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	B	-90,224		CAP REL COSTS-BLDG & FIXT	1.00	9	33.00
33.01	A	-13,522		CAP REL COSTS-BLDG & FIXT	1.00	9	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 141311

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

Worksheet A-8

Date/Time Prepared:  
11/22/2016 2:48 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.02 RECRUITING	A	-134,312	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 ADVERTISING	A	-93,804	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04 OTHER REVENUE	B	-5,335	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05 WAYFAIR RENTAL	B	-137,500	CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
33.06 PROVIDER TAX	A	-573,999	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07 HOSPITALIST IN THE RHC	A	-141,704	RURAL HEALTH CLINIC	88.00	0	33.07
33.08 340B REVENUE	B	-23,041	DRUGS CHARGED TO PATIENTS	73.00	0	33.08
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,752,858				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 141311

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

Worksheet A-8-1

Date/Time Prepared:  
11/22/2016 2:48 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	54.00	RADIOLOGY - DIAGNOSTIC	227,738	228,081	1.00
2.00	0.00	MRI	0	0	2.00
3.00	0.00		0	0	3.00
4.00	0.00		0	0	4.00
5.00	0	0	227,738	228,081	5.00

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

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

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

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

6.00	G	DSSI	15.00	DSSI	15.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	OTHER				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 141311

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

Worksheet A-8-1

Date/Time Prepared:  
11/22/2016 2:48 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	-343	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-343			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141311

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

Worksheet A-8-2

Date/Time Prepared:  
11/22/2016 2:48 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	295,781	295,781	0	0	0	1.00
2.00	50.00	OPERATING ROOM	491,063	491,063	0	0	0	2.00
3.00	60.00	LABORATORY	25,500	0	25,500	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	44,740	44,740	0	0	0	4.00
5.00	91.00	EMERGENCY	1,654,045	1,177,349	476,696	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,511,129	2,008,933	502,196	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	295,781	1.00
2.00	50.00	OPERATING ROOM	0	0	0	491,063	2.00
3.00	60.00	LABORATORY	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	44,740	4.00
5.00	91.00	EMERGENCY	0	0	0	1,177,349	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	2,008,933	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141311

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

Worksheet B  
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,269,157	1,269,157			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	631,068		631,068		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,972,216	0	0	2,972,216	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,642,672	246,361	122,499	305,503	3,317,035
6.00 00600	MAINTENANCE & REPAIRS	630,666	35,075	17,441	74,919	758,101
7.00 00700	OPERATION OF PLANT	585,232	22,925	11,399	0	619,556
8.00 00800	LAUNDRY & LINEN SERVICE	412,136	15,841	7,877	0	435,854
9.00 00900	HOUSEKEEPING	458,663	2,192	1,090	80,373	542,318
10.00 01000	DIETARY	425,766	1,622	807	58,302	486,497
11.00 01100	CAFETERIA	71,341	47,671	23,704	29,866	172,582
13.00 01300	NURSING ADMINISTRATION	247,047	1,585	788	59,676	309,096
16.00 01600	MEDICAL RECORDS & LIBRARY	318,443	18,244	9,071	58,774	404,532
17.00 01700	SOCIAL SERVICE	90,953	1,982	985	21,179	115,099
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	1,237,997	180,814	89,907	343,546	1,852,264
31.00 03100	INTENSIVE CARE UNIT	193,128	16,510	8,209	47,748	265,595
43.00 04300	NURSERY	0	0	0	0	0
44.00 04400	SKILLED NURSING FACILITY	714,290	105,932	52,673	170,700	1,043,595
45.00 04500	NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	764,817	80,406	39,981	269,817	1,155,021
52.00 05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0
54.00 05400	RADIOLOGY - DIAGNOSTIC	1,415,897	56,700	28,193	123,905	1,624,695
60.00 06000	LABORATORY	1,899,673	28,090	13,967	191,071	2,132,801
65.00 06500	RESPIRATORY THERAPY	220,637	20,857	10,371	30,425	282,290
66.00 06600	PHYSICAL THERAPY	744,765	44,699	22,226	185,147	996,837
69.00 06900	ELECTROCARDIOLOGY	39,530	0	0	10,011	49,541
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	942,039	21,996	10,937	12,388	987,360
72.00 07200	IMP. DEV CHARGED TO PATIENT	113,964	0	0	0	113,964
73.00 07300	DRUGS CHARGED TO PATIENTS	1,469,832	33,787	16,800	55,656	1,576,075
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	2,380,225	183,849	91,416	559,094	3,214,584
90.00 09000	CLINIC	346,250	21,489	10,685	57,410	435,834
90.01 09001	WOUND CARE	205,160	26,876	13,364	2,346	247,746
90.02 09002	CLINIC	199,908	1,115	554	17,423	219,000
91.00 09100	EMERGENCY	1,230,569	28,759	14,300	144,021	1,417,649
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100	HOME HEALTH AGENCY	312,245	23,780	11,824	62,916	410,765
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	25,186,286	1,269,157	631,068	2,972,216	25,186,286
<b>NONREIMBURSABLE COST CENTERS</b>						
194.00 07950	DR. OFFICE	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	25,186,286	1,269,157	631,068	2,972,216	25,186,286

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141311

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

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	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	
5.00	00500	ADMINISTRATIVE & GENERAL	3,317,035				5.00	
6.00	00600	MAINTENANCE & REPAIRS	114,986	873,087			6.00	
7.00	00700	OPERATION OF PLANT	93,972	20,265	733,793		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	66,109	14,002	12,048	528,013	8.00	
9.00	00900	HOUSEKEEPING	82,257	1,938	1,667	63,389	691,569	9.00
10.00	01000	DIETARY	73,790	1,434	1,234	0	1,185	10.00
11.00	01100	CAFETERIA	26,177	42,139	36,257	0	34,822	11.00
13.00	01300	NURSING ADMINISTRATION	46,882	1,401	1,206	0	1,158	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	61,358	16,126	13,876	0	13,326	16.00
17.00	01700	SOCIAL SERVICE	17,458	1,752	1,507	0	1,448	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	280,944	159,829	137,521	105,866	132,077	30.00
31.00	03100	INTENSIVE CARE UNIT	40,284	14,594	12,557	3,810	12,060	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	158,288	93,638	80,569	115,874	77,379	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	175,189	71,074	61,154	63,031	58,733	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	246,427	50,120	43,124	36,751	41,417	54.00
60.00	06000	LABORATORY	323,495	24,830	21,364	8,588	20,519	60.00
65.00	06500	RESPIRATORY THERAPY	42,817	18,436	15,863	8,377	15,235	65.00
66.00	06600	PHYSICAL THERAPY	151,196	39,511	33,996	32,310	32,651	66.00
69.00	06900	ELECTROCARDIOLOGY	7,514	0	0	12,977	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	149,759	19,444	16,730	0	16,067	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	17,286	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	239,053	29,866	25,698	0	24,680	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	487,568	162,510	139,830	6,673	134,292	88.00
90.00	09000	CLINIC	66,106	18,995	16,344	0	15,697	90.00
90.01	09001	WOUND CARE	37,577	23,757	20,441	0	19,632	90.01
90.02	09002	CLINIC	33,217	985	848	0	814	90.02
91.00	09100	EMERGENCY	215,023	25,421	21,873	70,367	21,007	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	62,303	21,020	18,086	0	17,370	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,317,035	873,087	733,793	528,013	691,569	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
194.00	07950	DR. OFFICE	0	0	0	0	0	194.00
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)	3,317,035	873,087	733,793	528,013	691,569	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141311

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

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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		10.00	11.00	13.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	564,140					10.00
11.00	01100	0	311,977				11.00
13.00	01300	0	5,697	365,440			13.00
16.00	01600	0	12,302	0	521,520		16.00
17.00	01700	0	4,022	0	0	141,286	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	123,779	49,317	131,687	39,964	141,286	30.00
31.00	03100	21,045	6,197	16,548	3,098	0	31.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	419,316	35,789	95,565	7,541	0	44.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	23,082	61,635	40,284	0	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	0	18,267	0	123,348	0	54.00
60.00	06000	0	34,886	0	90,078	0	60.00
65.00	06500	0	5,684	0	24,474	0	65.00
66.00	06600	0	18,882	0	23,776	0	66.00
69.00	06900	0	1,696	0	11,342	0	69.00
71.00	07100	0	3,527	0	36,257	0	71.00
72.00	07200	0	0	0	1,630	0	72.00
73.00	07300	0	5,988	0	47,655	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	51,777	0	31,392	0	88.00
90.00	09000	0	8,549	0	6,946	0	90.00
90.01	09001	0	279	0	5,371	0	90.01
90.02	09002	0	3,564	0	1,829	0	90.02
91.00	09100	0	22,472	60,005	26,535	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	0	0	0	0	113.00
118.00		564,140	311,977	365,440	521,520	141,286	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	0	0	0	0	0	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		564,140	311,977	365,440	521,520	141,286	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141311

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

Worksheet B  
Part I  
Date/Time Prepared:  
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
16.00	01600				16.00
17.00	01700				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	3,154,534	0	3,154,534	30.00
31.00	03100	395,788	0	395,788	31.00
43.00	04300	0	0	0	43.00
44.00	04400	2,127,554	0	2,127,554	44.00
45.00	04500	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	1,709,203	0	1,709,203	50.00
52.00	05200	0	0	0	52.00
54.00	05400	2,184,149	0	2,184,149	54.00
60.00	06000	2,656,561	0	2,656,561	60.00
65.00	06500	413,176	0	413,176	65.00
66.00	06600	1,329,159	0	1,329,159	66.00
69.00	06900	83,070	0	83,070	69.00
71.00	07100	1,229,144	0	1,229,144	71.00
72.00	07200	132,880	0	132,880	72.00
73.00	07300	1,949,015	0	1,949,015	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	4,228,626	0	4,228,626	88.00
90.00	09000	568,471	0	568,471	90.00
90.01	09001	354,803	0	354,803	90.01
90.02	09002	260,257	0	260,257	90.02
91.00	09100	1,880,352	0	1,880,352	91.00
92.00	09200		0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	529,544	0	529,544	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
118.00		25,186,286	0	25,186,286	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
194.00	07950	0	0	0	194.00
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		25,186,286	0	25,186,286	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141311

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

Worksheet B  
Part II  
Date/Time Prepared:  
11/22/2016 2:48 pm

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	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	246,361	122,499	368,860	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	35,075	17,441	52,516	6.00
7.00 00700	OPERATION OF PLANT	0	22,925	11,399	34,324	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	15,841	7,877	23,718	8.00
9.00 00900	HOUSEKEEPING	0	2,192	1,090	3,282	9.00
10.00 01000	DIETARY	0	1,622	807	2,429	10.00
11.00 01100	CAFETERIA	0	47,671	23,704	71,375	11.00
13.00 01300	NURSING ADMINISTRATION	0	1,585	788	2,373	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	18,244	9,071	27,315	16.00
17.00 01700	SOCIAL SERVICE	0	1,982	985	2,967	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	180,814	89,907	270,721	30.00
31.00 03100	INTENSIVE CARE UNIT	0	16,510	8,209	24,719	31.00
43.00 04300	NURSERY	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	105,932	52,673	158,605	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	80,406	39,981	120,387	50.00
52.00 05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	52.00
54.00 05400	RADIOLOGY - DIAGNOSTIC	0	56,700	28,193	84,893	54.00
60.00 06000	LABORATORY	0	28,090	13,967	42,057	60.00
65.00 06500	RESPIRATORY THERAPY	0	20,857	10,371	31,228	65.00
66.00 06600	PHYSICAL THERAPY	0	44,699	22,226	66,925	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,996	10,937	32,933	71.00
72.00 07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	33,787	16,800	50,587	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	183,849	91,416	275,265	88.00
90.00 09000	CLINIC	0	21,489	10,685	32,174	90.00
90.01 09001	WOUND CARE	0	26,876	13,364	40,240	90.01
90.02 09002	CLINIC	0	1,115	554	1,669	90.02
91.00 09100	EMERGENCY	0	28,759	14,300	43,059	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100	HOME HEALTH AGENCY	0	23,780	11,824	35,604	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,269,157	631,068	1,900,225	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
194.00 07950	DR. OFFICE	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,269,157	631,068	1,900,225	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141311

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

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	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	
5.00	00500	ADMINISTRATIVE & GENERAL	368,860				5.00	
6.00	00600	MAINTENANCE & REPAIRS	12,787	65,303			6.00	
7.00	00700	OPERATION OF PLANT	10,450	1,516	46,290		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	7,352	1,047	760	32,877	8.00	
9.00	00900	HOUSEKEEPING	9,147	145	105	3,947	16,626	9.00
10.00	01000	DIETARY	8,206	107	78	0	28	10.00
11.00	01100	CAFETERIA	2,911	3,152	2,287	0	837	11.00
13.00	01300	NURSING ADMINISTRATION	5,214	105	76	0	28	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,823	1,206	875	0	320	16.00
17.00	01700	SOCIAL SERVICE	1,941	131	95	0	35	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	31,242	11,954	8,675	6,592	3,175	30.00
31.00	03100	INTENSIVE CARE UNIT	4,480	1,092	792	237	290	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	17,602	7,004	5,083	7,215	1,860	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	19,482	5,316	3,858	3,925	1,412	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	27,404	3,749	2,720	2,288	996	54.00
60.00	06000	LABORATORY	35,974	1,857	1,348	535	493	60.00
65.00	06500	RESPIRATORY THERAPY	4,761	1,379	1,001	522	366	65.00
66.00	06600	PHYSICAL THERAPY	16,814	2,955	2,145	2,012	785	66.00
69.00	06900	ELECTROCARDIOLOGY	836	0	0	808	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,654	1,454	1,055	0	386	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	1,922	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,584	2,234	1,621	0	593	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	54,211	12,155	8,822	415	3,230	88.00
90.00	09000	CLINIC	7,351	1,421	1,031	0	377	90.00
90.01	09001	WOUND CARE	4,179	1,777	1,289	0	472	90.01
90.02	09002	CLINIC	3,694	74	53	0	20	90.02
91.00	09100	EMERGENCY	23,911	1,901	1,380	4,381	505	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	6,928	1,572	1,141	0	418	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	368,860	65,303	46,290	32,877	16,626	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
194.00	07950	DR. OFFICE	0	0	0	0	0	194.00
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)	368,860	65,303	46,290	32,877	16,626	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141311

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

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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		10.00	11.00	13.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	10,848					10.00
11.00	01100	0	80,562				11.00
13.00	01300	0	1,471	9,267			13.00
16.00	01600	0	3,177	0	39,716		16.00
17.00	01700	0	1,039	0	0	6,208	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,380	12,735	3,339	3,046	6,208	30.00
31.00	03100	405	1,600	420	236	0	31.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	8,063	9,242	2,423	575	0	44.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	5,961	1,563	3,070	0	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	0	4,717	0	9,372	0	54.00
60.00	06000	0	9,009	0	6,865	0	60.00
65.00	06500	0	1,468	0	1,865	0	65.00
66.00	06600	0	4,876	0	1,812	0	66.00
69.00	06900	0	438	0	864	0	69.00
71.00	07100	0	911	0	2,763	0	71.00
72.00	07200	0	0	0	124	0	72.00
73.00	07300	0	1,546	0	3,632	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	13,369	0	2,393	0	88.00
90.00	09000	0	2,208	0	529	0	90.00
90.01	09001	0	72	0	409	0	90.01
90.02	09002	0	920	0	139	0	90.02
91.00	09100	0	5,803	1,522	2,022	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	0	0	0	0	113.00
118.00		10,848	80,562	9,267	39,716	6,208	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	0	0	0	0	0	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		10,848	80,562	9,267	39,716	6,208	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141311

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

Worksheet B  
Part II  
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
16.00	01600				16.00
17.00	01700				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	360,067	0	360,067	30.00
31.00	03100	34,271	0	34,271	31.00
43.00	04300	0	0	0	43.00
44.00	04400	217,672	0	217,672	44.00
45.00	04500	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	164,974	0	164,974	50.00
52.00	05200	0	0	0	52.00
54.00	05400	136,139	0	136,139	54.00
60.00	06000	98,138	0	98,138	60.00
65.00	06500	42,590	0	42,590	65.00
66.00	06600	98,324	0	98,324	66.00
69.00	06900	2,946	0	2,946	69.00
71.00	07100	56,156	0	56,156	71.00
72.00	07200	2,046	0	2,046	72.00
73.00	07300	86,797	0	86,797	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	369,860	0	369,860	88.00
90.00	09000	45,091	0	45,091	90.00
90.01	09001	48,438	0	48,438	90.01
90.02	09002	6,569	0	6,569	90.02
91.00	09100	84,484	0	84,484	91.00
92.00	09200		0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	45,663	0	45,663	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
118.00		1,900,225	0	1,900,225	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
194.00	07950	0	0	0	194.00
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		1,900,225	0	1,900,225	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141311

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

Worksheet B-1  
Date/Time Prepared: 11/22/2016 2:48 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	102,472				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		102,472			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	11,735,847		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	19,891	19,891	1,206,281	-3,317,035	21,869,251
6.00 00600	MAINTENANCE & REPAIRS	2,832	2,832	295,817	0	758,101
7.00 00700	OPERATION OF PLANT	1,851	1,851	0	0	619,556
8.00 00800	LAUNDRY & LINEN SERVICE	1,279	1,279	0	0	435,854
9.00 00900	HOUSEKEEPING	177	177	317,352	0	542,318
10.00 01000	DIETARY	131	131	230,206	0	486,497
11.00 01100	CAFETERIA	3,849	3,849	117,928	0	172,582
13.00 01300	NURSING ADMINISTRATION	128	128	235,632	0	309,096
16.00 01600	MEDICAL RECORDS & LIBRARY	1,473	1,473	232,070	0	404,532
17.00 01700	SOCIAL SERVICE	160	160	83,626	0	115,099
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	14,599	14,599	1,356,497	0	1,852,264
31.00 03100	INTENSIVE CARE UNIT	1,333	1,333	188,533	0	265,595
43.00 04300	NURSERY	0	0	0	0	0
44.00 04400	SKILLED NURSING FACILITY	8,553	8,553	674,009	0	1,043,595
45.00 04500	NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	6,492	6,492	1,065,377	0	1,155,021
52.00 05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0
54.00 05400	RADIOLOGY - DIAGNOSTIC	4,578	4,578	489,242	0	1,624,695
60.00 06000	LABORATORY	2,268	2,268	754,446	0	2,132,801
65.00 06500	RESPIRATORY THERAPY	1,684	1,684	120,135	0	282,290
66.00 06600	PHYSICAL THERAPY	3,609	3,609	731,057	0	996,837
69.00 06900	ELECTROCARDIOLOGY	0	0	39,530	0	49,541
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,776	1,776	48,914	0	987,360
72.00 07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	113,964
73.00 07300	DRUGS CHARGED TO PATIENTS	2,728	2,728	219,759	0	1,576,075
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	14,844	14,844	2,207,597	0	3,214,584
90.00 09000	CLINIC	1,735	1,735	226,686	0	435,834
90.01 09001	WOUND CARE	2,170	2,170	9,262	0	247,746
90.02 09002	CLINIC	90	90	68,795	0	219,000
91.00 09100	EMERGENCY	2,322	2,322	568,670	0	1,417,649
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100	HOME HEALTH AGENCY	1,920	1,920	248,426	0	410,765
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	102,472	102,472	11,735,847	-3,317,035	21,869,251
<b>NONREIMBURSABLE COST CENTERS</b>						
194.00 07950	DR. OFFICE	0	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	1,269,157	631,068	2,972,216		3,317,035
203.00	Unit cost multiplier (Wkst. B, Part I)	12.385403	6.158443	0.253260		0.151676
204.00	Cost to be allocated (per Wkst. B, Part II)			0		368,860
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.016867

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141311

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	79,749					6.00
7.00	00700	1,851	77,898				7.00
8.00	00800	1,279	1,279	50,170			8.00
9.00	00900	177	177	6,023	76,442		9.00
10.00	01000	131	131	0	131	85,164	10.00
11.00	01100	3,849	3,849	0	3,849	0	11.00
13.00	01300	128	128	0	128	0	13.00
16.00	01600	1,473	1,473	0	1,473	0	16.00
17.00	01700	160	160	0	160	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	14,599	14,599	10,059	14,599	18,686	30.00
31.00	03100	1,333	1,333	362	1,333	3,177	31.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	8,553	8,553	11,010	8,553	63,301	44.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	6,492	6,492	5,989	6,492	0	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	4,578	4,578	3,492	4,578	0	54.00
60.00	06000	2,268	2,268	816	2,268	0	60.00
65.00	06500	1,684	1,684	796	1,684	0	65.00
66.00	06600	3,609	3,609	3,070	3,609	0	66.00
69.00	06900	0	0	1,233	0	0	69.00
71.00	07100	1,776	1,776	0	1,776	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	2,728	2,728	0	2,728	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	14,844	14,844	634	14,844	0	88.00
90.00	09000	1,735	1,735	0	1,735	0	90.00
90.01	09001	2,170	2,170	0	2,170	0	90.01
90.02	09002	90	90	0	90	0	90.02
91.00	09100	2,322	2,322	6,686	2,322	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	1,920	1,920	0	1,920	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		79,749	77,898	50,170	76,442	85,164	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		873,087	733,793	528,013	691,569	564,140	202.00
203.00		10.947937	9.419921	10.524477	9.046977	6.624160	203.00
204.00		65,303	46,290	32,877	16,626	10,848	204.00
205.00		0.818857	0.594239	0.655312	0.217498	0.127378	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141311

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		CAFETERIA (PAID HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		11.00	13.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
6.00	00600					6.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100	353,250				11.00
13.00	01300	6,451	154,963			13.00
16.00	01600	13,929	0	71,621,867		16.00
17.00	01700	4,554	0	0	100	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	55,841	55,841	5,488,011	100	30.00
31.00	03100	7,017	7,017	425,415	0	31.00
43.00	04300	0	0	0	0	43.00
44.00	04400	40,524	40,524	1,035,520	0	44.00
45.00	04500	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	26,136	26,136	5,531,956	0	50.00
52.00	05200	0	0	0	0	52.00
54.00	05400	20,684	0	16,943,080	0	54.00
60.00	06000	39,501	0	12,369,937	0	60.00
65.00	06500	6,436	0	3,360,920	0	65.00
66.00	06600	21,380	0	3,265,085	0	66.00
69.00	06900	1,920	0	1,557,475	0	69.00
71.00	07100	3,994	0	4,978,967	0	71.00
72.00	07200	0	0	223,879	0	72.00
73.00	07300	6,780	0	6,544,257	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	58,627	0	4,310,884	0	88.00
90.00	09000	9,680	0	953,843	0	90.00
90.01	09001	316	0	737,572	0	90.01
90.02	09002	4,035	0	251,208	0	90.02
91.00	09100	25,445	25,445	3,643,858	0	91.00
92.00	09200					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300					113.00
118.00		353,250	154,963	71,621,867	100	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
194.00	07950	0	0	0	0	194.00
200.00						200.00
201.00						201.00
202.00		311,977	365,440	521,520	141,286	202.00
203.00		0.883162	2.358240	0.007282	1,412.860000	203.00
204.00		80,562	9,267	39,716	6,208	204.00
205.00		0.228059	0.059801	0.000555	62.080000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141311

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/22/2016 2:48 pm

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		3,154,534	0	3,154,534	30.00
31.00	03100 INTENSIVE CARE UNIT		395,788	0	395,788	31.00
43.00	04300 NURSERY		0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY		2,127,554	0	2,127,554	44.00
45.00	04500 NURSING FACILITY		0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		1,709,203	0	1,709,203	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM		0	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC		2,184,149	0	2,184,149	54.00
60.00	06000 LABORATORY		2,656,561	0	2,656,561	60.00
65.00	06500 RESPIRATORY THERAPY	0	413,176	0	413,176	65.00
66.00	06600 PHYSICAL THERAPY	0	1,329,159	0	1,329,159	66.00
69.00	06900 ELECTROCARDIOLOGY		83,070	0	83,070	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1,229,144	0	1,229,144	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT		132,880	0	132,880	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,949,015	0	1,949,015	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC		4,228,626	0	4,228,626	88.00
90.00	09000 CLINIC		568,471	0	568,471	90.00
90.01	09001 WOUND CARE		354,803	0	354,803	90.01
90.02	09002 CLINIC		260,257	0	260,257	90.02
91.00	09100 EMERGENCY		1,880,352	0	1,880,352	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		928,479	0	928,479	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100 HOME HEALTH AGENCY		529,544		529,544	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		26,114,765	0	26,114,765	200.00
201.00	Less Observation Beds		928,479		928,479	201.00
202.00	Total (see instructions)		25,186,286	0	25,186,286	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141311

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/22/2016 2:48 pm

		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	4,281,248		4,281,248		30.00
31.00	03100	INTENSIVE CARE UNIT	425,415		425,415		31.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	1,035,520		1,035,520		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	528,908	5,003,047	5,531,955	0.308969	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,029,292	15,913,788	16,943,080	0.128911	54.00
60.00	06000	LABORATORY	1,394,056	10,975,882	12,369,938	0.214759	60.00
65.00	06500	RESPIRATORY THERAPY	532,181	1,925,367	2,457,548	0.168125	65.00
66.00	06600	PHYSICAL THERAPY	1,250,092	2,014,992	3,265,084	0.407083	66.00
69.00	06900	ELECTROCARDIOLOGY	228,681	1,328,794	1,557,475	0.053336	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,704,337	4,176,031	5,880,368	0.209025	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	13,193	212,658	225,851	0.588352	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,781,542	4,762,715	6,544,257	0.297821	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	4,310,884	4,310,884		88.00
90.00	09000	CLINIC	500	953,343	953,843	0.595980	90.00
90.01	09001	WOUND CARE	4,000	733,572	737,572	0.481042	90.01
90.02	09002	CLINIC	0	251,208	251,208	1.036022	90.02
91.00	09100	EMERGENCY	73,237	3,570,621	3,643,858	0.516033	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	154,530	1,052,233	1,206,763	0.769396	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	0	519,227	519,227		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	14,436,732	57,704,362	72,141,094		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	14,436,732	57,704,362	72,141,094		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/22/2016 2:48 pm
	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
31.00	03100 INTENSIVE CARE UNIT		31.00
43.00	04300 NURSERY		43.00
44.00	04400 SKILLED NURSING FACILITY		44.00
45.00	04500 NURSING FACILITY		45.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	0.000000	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0.000000	52.00
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
69.00	06900 ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800 RURAL HEALTH CLINIC		88.00
90.00	09000 CLINIC	0.000000	90.00
90.01	09001 WOUND CARE	0.000000	90.01
90.02	09002 CLINIC	0.000000	90.02
91.00	09100 EMERGENCY	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
101.00	10100 HOME HEALTH AGENCY		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300 INTEREST EXPENSE		113.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141311

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/22/2016 2:48 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		3,154,534	0	3,154,534	30.00
31.00	03100 INTENSIVE CARE UNIT		395,788	0	395,788	31.00
43.00	04300 NURSERY		0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY		2,127,554	0	2,127,554	44.00
45.00	04500 NURSING FACILITY		0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		1,709,203	0	1,709,203	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM		0	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC		2,184,149	0	2,184,149	54.00
60.00	06000 LABORATORY		2,656,561	0	2,656,561	60.00
65.00	06500 RESPIRATORY THERAPY	0	413,176	0	413,176	65.00
66.00	06600 PHYSICAL THERAPY	0	1,329,159	0	1,329,159	66.00
69.00	06900 ELECTROCARDIOLOGY		83,070	0	83,070	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1,229,144	0	1,229,144	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT		132,880	0	132,880	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,949,015	0	1,949,015	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC		4,228,626	0	4,228,626	88.00
90.00	09000 CLINIC		568,471	0	568,471	90.00
90.01	09001 WOUND CARE		354,803	0	354,803	90.01
90.02	09002 CLINIC		260,257	0	260,257	90.02
91.00	09100 EMERGENCY		1,880,352	0	1,880,352	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		928,479	0	928,479	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100 HOME HEALTH AGENCY		529,544		529,544	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		26,114,765	0	26,114,765	200.00
201.00	Less Observation Beds		928,479		928,479	201.00
202.00	Total (see instructions)		25,186,286	0	25,186,286	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141311

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/22/2016 2:48 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX Hospital Cost							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,281,248		4,281,248		30.00
31.00	03100	INTENSIVE CARE UNIT	425,415		425,415		31.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	1,035,520		1,035,520		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	528,908	5,003,047	5,531,955	0.308969	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,029,292	15,913,788	16,943,080	0.128911	54.00
60.00	06000	LABORATORY	1,394,056	10,975,882	12,369,938	0.214759	60.00
65.00	06500	RESPIRATORY THERAPY	532,181	1,925,367	2,457,548	0.168125	65.00
66.00	06600	PHYSICAL THERAPY	1,250,092	2,014,992	3,265,084	0.407083	66.00
69.00	06900	ELECTROCARDIOLOGY	228,681	1,328,794	1,557,475	0.053336	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,704,337	4,176,031	5,880,368	0.209025	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	13,193	212,658	225,851	0.588352	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,781,542	4,762,715	6,544,257	0.297821	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	4,310,884	4,310,884	0.980919	88.00
90.00	09000	CLINIC	500	953,343	953,843	0.595980	90.00
90.01	09001	WOUND CARE	4,000	733,572	737,572	0.481042	90.01
90.02	09002	CLINIC	0	251,208	251,208	1.036022	90.02
91.00	09100	EMERGENCY	73,237	3,570,621	3,643,858	0.516033	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	154,530	1,052,233	1,206,763	0.769396	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	519,227	519,227		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	14,436,732	57,704,362	72,141,094		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	14,436,732	57,704,362	72,141,094		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/22/2016 2:48 pm
Cost Center Description		PPS Inpatient Ratio 11.00	Title XIX	Hospital Cost
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
45.00	04500 NURSING FACILITY			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0.000000		52.00
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
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 WOUND CARE	0.000000		90.01
90.02	09002 CLINIC	0.000000		90.02
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00	10100 HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Prepared: 11/22/2016 2:48 pm
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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	164,974	5,531,955	0.029822	328,106	9,785	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0	0	0.000000	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	136,139	16,943,080	0.008035	751,237	6,036	54.00
60.00	06000 LABORATORY	98,138	12,369,938	0.007934	994,142	7,888	60.00
65.00	06500 RESPIRATORY THERAPY	42,590	2,457,548	0.017330	399,764	6,928	65.00
66.00	06600 PHYSICAL THERAPY	98,324	3,265,084	0.030114	181,432	5,464	66.00
69.00	06900 ELECTROCARDIOLOGY	2,946	1,557,475	0.001892	99,942	189	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	56,156	5,880,368	0.009550	934,386	8,923	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	2,046	225,851	0.009059	13,193	120	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	86,797	6,544,257	0.013263	877,647	11,640	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	369,860	4,310,884	0.085797	0	0	88.00
90.00	09000 CLINIC	45,091	953,843	0.047273	0	0	90.00
90.01	09001 WOUND CARE	48,438	737,572	0.065672	3,706	243	90.01
90.02	09002 CLINIC	6,569	251,208	0.026150	0	0	90.02
91.00	09100 EMERGENCY	84,484	3,643,858	0.023185	47,156	1,093	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	105,979	1,206,763	0.087821	50,265	4,414	92.00
200.00	Total (lines 50-199)	1,348,531	65,879,684		4,680,976	62,723	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141311

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/22/2016 2:48 pm

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
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	0	52.00
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
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	IMP. DEV CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
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
90.01	09001	WOUND CARE	0	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	0	90.02
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
200.00		Total (Lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141311

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/22/2016 2:48 pm

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 Cost			
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	5,531,955	0.000000	0.000000	328,106	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	16,943,080	0.000000	0.000000	751,237	54.00
60.00	06000	LABORATORY	0	12,369,938	0.000000	0.000000	994,142	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,457,548	0.000000	0.000000	399,764	65.00
66.00	06600	PHYSICAL THERAPY	0	3,265,084	0.000000	0.000000	181,432	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,557,475	0.000000	0.000000	99,942	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,880,368	0.000000	0.000000	934,386	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	225,851	0.000000	0.000000	13,193	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,544,257	0.000000	0.000000	877,647	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	4,310,884	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	953,843	0.000000	0.000000	0	90.00
90.01	09001	WOUND CARE	0	737,572	0.000000	0.000000	3,706	90.01
90.02	09002	CLINIC	0	251,208	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	3,643,858	0.000000	0.000000	47,156	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,206,763	0.000000	0.000000	50,265	92.00
200.00		Total (lines 50-199)	0	65,879,684			4,680,976	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141311

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/22/2016 2:48 pm

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)	Hospital	Cost
		11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0	0	0		52.00
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
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 IMP. DEV CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
<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
90.01	09001 WOUND CARE	0	0	0		90.01
90.02	09002 CLINIC	0	0	0		90.02
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/22/2016 2:48 pm
	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	0.308969	0	2,427,747	0	0
52.00 05200 LABOR ROOM & DELIVERY ROOM	0.000000	0	0	0	0
54.00 05400 RADIOLOGY - DIAGNOSTIC	0.128911	0	7,187,871	0	0
60.00 06000 LABORATORY	0.214759	0	5,094,845	0	0
65.00 06500 RESPIRATORY THERAPY	0.168125	0	864,624	0	0
66.00 06600 PHYSICAL THERAPY	0.407083	0	714,598	0	0
69.00 06900 ELECTROCARDIOLOGY	0.053336	0	471,435	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.209025	0	1,498,734	0	0
72.00 07200 IMP. DEV CHARGED TO PATIENT	0.588352	0	212,658	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.297821	0	2,423,087	4,965	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
90.00 09000 CLINIC	0.595980	0	914,420	0	0
90.01 09001 WOUND CARE	0.481042	0	449,182	0	0
90.02 09002 CLINIC	1.036022	0	0	0	0
91.00 09100 EMERGENCY	0.516033	0	1,126,066	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.769396	0	494,608	0	0
200.00 Subtotal (see instructions)		0	23,879,875	4,965	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	23,879,875	4,965	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/22/2016 2:48 pm
		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	750,099	0	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	926,596	0	54.00
60.00	06000 LABORATORY	1,094,164	0	60.00
65.00	06500 RESPIRATORY THERAPY	145,365	0	65.00
66.00	06600 PHYSICAL THERAPY	290,901	0	66.00
69.00	06900 ELECTROCARDIOLOGY	25,144	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	313,273	0	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	125,118	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	721,646	1,479	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	544,976	0	90.00
90.01	09001 WOUND CARE	216,075	0	90.01
90.02	09002 CLINIC	0	0	90.02
91.00	09100 EMERGENCY	581,087	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	380,549	0	92.00
200.00	Subtotal (see instructions)	6,114,993	1,479	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	6,114,993	1,479	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141311 Component CCN: 145552	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/22/2016 2:48 pm
		Title XVIII	Skilled Nursing Facility PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141311 Component CCN: 145552	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/22/2016 2:48 pm
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	5,531,955	0.000000	0.000000	0	50.00
52.00 05200 LABOR ROOM & DELIVERY ROOM	0	0	0.000000	0.000000	0	52.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	16,943,080	0.000000	0.000000	0	54.00
60.00 06000 LABORATORY	0	12,369,938	0.000000	0.000000	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	2,457,548	0.000000	0.000000	0	65.00
66.00 06600 PHYSICAL THERAPY	0	3,265,084	0.000000	0.000000	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	1,557,475	0.000000	0.000000	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,880,368	0.000000	0.000000	0	71.00
72.00 07200 IMP. DEV CHARGED TO PATIENT	0	225,851	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	6,544,257	0.000000	0.000000	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	4,310,884	0.000000	0.000000	0	88.00
90.00 09000 CLINIC	0	953,843	0.000000	0.000000	0	90.00
90.01 09001 WOUND CARE	0	737,572	0.000000	0.000000	0	90.01
90.02 09002 CLINIC	0	251,208	0.000000	0.000000	0	90.02
91.00 09100 EMERGENCY	0	3,643,858	0.000000	0.000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,206,763	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	65,879,684			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/22/2016 2:48 pm
	Component CCN: 145552	Title XVIII	Skilled Nursing Facility PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0	0	50.00
52.00 05200 LABOR ROOM & DELIVERY ROOM	0	0	0	52.00
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
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 IMP. DEV CHARGED TO PATIENT	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
<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
90.01 09001 WOUND CARE	0	0	0	90.01
90.02 09002 CLINIC	0	0	0	90.02
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141311 Component CCN: 145552	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/22/2016 2:48 pm PPS
		Title XVIII	Skilled Nursing Facility

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS Services (see inst.)	Costs (see inst.)	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0.308969	0	0	0	0	0	50.00
52.00 05200 LABOR ROOM & DELIVERY ROOM	0.000000	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0.128911	0	0	0	0	0	54.00
60.00 06000 LABORATORY	0.214759	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.168125	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.407083	0	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.053336	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.209025	0	0	0	0	0	71.00
72.00 07200 IMP. DEV CHARGED TO PATIENT	0.588352	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.297821	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800 RURAL HEALTH CLINIC	0.000000					0	88.00
90.00 09000 CLINIC	0.595980	0	0	0	0	0	90.00
90.01 09001 WOUND CARE	0.481042	0	0	0	0	0	90.01
90.02 09002 CLINIC	1.036022	0	0	0	0	0	90.02
91.00 09100 EMERGENCY	0.516033	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.769396	0	0	0	0	0	92.00
200.00 Subtotal (see instructions)		0	0	0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141311	Period: From 07/01/2015	Worksheet D Part V Date/Time Prepared: 11/22/2016 2:48 pm
	Component CCN: 145552	To 06/30/2016	
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
52.00 05200 LABOR ROOM & DELIVERY ROOM	0	0	52.00
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
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMP. DEV CHARGED TO PATIENT	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00 08800 RURAL HEALTH CLINIC	0	0	88.00
90.00 09000 CLINIC	0	0	90.00
90.01 09001 WOUND CARE	0	0	90.01
90.02 09002 CLINIC	0	0	90.02
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/22/2016 2:48 pm
	Title XIX	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	0.308969	1,391,119	0	429,813	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0.000000	0	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.128911	3,577,324	0	461,156	54.00
60.00	06000 LABORATORY	0.214759	1,902,103	0	408,494	60.00
65.00	06500 RESPIRATORY THERAPY	0.168125	262,853	0	44,192	65.00
66.00	06600 PHYSICAL THERAPY	0.407083	283,012	0	115,209	66.00
69.00	06900 ELECTROCARDIOLOGY	0.053336	160,864	0	8,580	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.209025	1,052,635	0	220,027	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0.588352	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.297821	868,673	0	258,709	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0.980919	0	0	0	88.00
90.00	09000 CLINIC	0.595980	0	0	0	90.00
90.01	09001 WOUND CARE	0.481042	282,080	0	135,692	90.01
90.02	09002 CLINIC	1.036022	106,428	0	110,262	90.02
91.00	09100 EMERGENCY	0.516033	1,319,700	0	681,009	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.769396	0	0	0	92.00
200.00	Subtotal (see instructions)		11,206,791	0	2,873,143	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		11,206,791	0	2,873,143	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/22/2016 2:48 pm
		Title XIX	Hospital	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
52.00	05200 LABOR ROOM & DELIVERY ROOM	0	0	52.00
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
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	0	0	90.00
90.01	09001 WOUND CARE	0	0	90.01
90.02	09002 CLINIC	0	0	90.02
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/22/2016 2:48 pm
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)		3,034	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,034	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,141	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,435	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<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		188.27	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		192.90	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,154,534	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,154,534	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)		3,154,534	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)		1,039.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,492,013	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,492,013	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1	
		Title XVIII		Hospital		Date/Time Prepared: 11/22/2016 2:48 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	395,788	364	1,087.33	131	142,440	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)					1,087,363	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,721,816	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)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					893	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,039.73	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					928,479	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/22/2016 2:48 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	360,067	3,154,534	0.114143	928,479	105,979	90.00
91.00	Nursing School cost	0	3,154,534	0.000000	928,479	0	91.00
92.00	Allied health cost	0	3,154,534	0.000000	928,479	0	92.00
93.00	All other Medical Education	0	3,154,534	0.000000	928,479	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1
		Component CCN: 145552		Date/Time Prepared: 11/22/2016 2:48 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				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)		7,253	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,253	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)		7,253	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<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		188.27	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		192.90	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,127,554	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,127,554	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)		2,127,554	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1	
		Component CCN: 145552		Date/Time Prepared: 11/22/2016 2:48 pm		PPS	
		Title XVIII		Skilled Nursing Facility			
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						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)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						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						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						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)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						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)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						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)						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)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						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)					2,127,554	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					293.33	71.00
72.00	Program routine service cost (line 9 x line 71)					0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					0	83.00
84.00	Program inpatient ancillary services (see instructions)					0	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					0	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311 Component CCN: 145552		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/22/2016 2:48 pm	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital -related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/22/2016 2:48 pm
Cost Center Description		Title XIX	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)		3,034	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,034	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,141	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		242	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<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		188.27	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		192.90	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,154,534	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,154,534	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)		3,154,534	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)		1,039.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		251,615	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)		251,615	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1	
Date/Time Prepared: 11/22/2016 2:48 pm		Title XIX		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	395,788	364	1,087.33	21	22,834		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)					169,847		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					444,296		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)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						893	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,039.73	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						928,479	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/22/2016 2:48 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	360,067	3,154,534	0.114143	928,479	105,979	90.00
91.00	Nursing School cost	0	3,154,534	0.000000	928,479	0	91.00
92.00	Allied health cost	0	3,154,534	0.000000	928,479	0	92.00
93.00	All other Medical Education	0	3,154,534	0.000000	928,479	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/22/2016 2:48 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		1,542,784		30.00
31.00	03100 INTENSIVE CARE UNIT		265,660		31.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.308969	328,106	101,375	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0.000000	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.128911	751,237	96,843	54.00
60.00	06000 LABORATORY	0.214759	994,142	213,501	60.00
65.00	06500 RESPIRATORY THERAPY	0.168125	399,764	67,210	65.00
66.00	06600 PHYSICAL THERAPY	0.407083	181,432	73,858	66.00
69.00	06900 ELECTROCARDIOLOGY	0.053336	99,942	5,331	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.209025	934,386	195,310	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0.588352	13,193	7,762	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.297821	877,647	261,382	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.595980	0	0	90.00
90.01	09001 WOUND CARE	0.481042	3,706	1,783	90.01
90.02	09002 CLINIC	1.036022	0	0	90.02
91.00	09100 EMERGENCY	0.516033	47,156	24,334	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.769396	50,265	38,674	92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,680,976	1,087,363	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		4,680,976		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141311 Component CCN: 145552	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/22/2016 2:48 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.308969	0	0 50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0.000000	0	0 52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.128911	0	0 54.00
60.00	06000 LABORATORY	0.214759	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	0.168125	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.407083	0	0 66.00
69.00	06900 ELECTROCARDIOLOGY	0.053336	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.209025	0	0 71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0.588352	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.297821	0	0 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		0 88.00
90.00	09000 CLINIC	0.595980	0	0 90.00
90.01	09001 WOUND CARE	0.481042	0	0 90.01
90.02	09002 CLINIC	1.036022	0	0 90.02
91.00	09100 EMERGENCY	0.516033	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.769396	0	0 92.00
200.00	Total (sum of lines 50-94 and 96-98)		0	0 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net Charges (line 200 minus line 201)		0	0 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/22/2016 2:48 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		1,043,764		30.00
31.00	03100 INTENSIVE CARE UNIT		61,030		31.00
43.00	04300 NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.308969	110,536	34,152	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0.000000	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.128911	96,723	12,469	54.00
60.00	06000 LABORATORY	0.214759	121,404	26,073	60.00
65.00	06500 RESPIRATORY THERAPY	0.168125	90,171	15,160	65.00
66.00	06600 PHYSICAL THERAPY	0.407083	8,996	3,662	66.00
69.00	06900 ELECTROCARDIOLOGY	0.053336	16,559	883	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.209025	130,767	27,334	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0.588352	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.297821	157,167	46,808	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.980919	0	0	88.00
90.00	09000 CLINIC	0.595980	0	0	90.00
90.01	09001 WOUND CARE	0.481042	0	0	90.01
90.02	09002 CLINIC	1.036022	0	0	90.02
91.00	09100 EMERGENCY	0.516033	6,407	3,306	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.769396	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		738,730	169,847	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		738,730		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/22/2016 2:48 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			6,116,472 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)			6,116,472 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)			6,177,637 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)			102,570 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			3,775,034 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)			2,300,033 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)			2,300,033 30.00
31.00	Primary payer payments			169 31.00
32.00	Subtotal (line 30 minus line 31)			2,299,864 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)			727,811 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			473,077 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			656,821 36.00
37.00	Subtotal (see instructions)			2,772,941 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)			2,772,941 40.00
40.01	Sequestration adjustment (see instructions)			55,459 40.01
41.00	Interim payments			3,028,105 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-310,623 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			138,047 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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/22/2016 2:48 pm
		Component CCN: 145552	Title XVIII	Skilled Nursing Facility PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			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)		0	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)		0	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)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			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)		0	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)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R			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)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	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)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141311

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/22/2016 2:48 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,234,965		3,028,105	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,234,965		3,028,105	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		26,610		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		310,623	6.02	
7.00	Total Medicare program liability (see instructions)		2,261,575		2,717,482	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: 141311  
Component CCN: 145552

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/22/2016 2:48 pm  
PPS

Title XVIII

Skilled Nursing Facility

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
<b>Program to Provider</b>						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
<b>Provider to Program</b>						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0	4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>						
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
<b>Program to Provider</b>						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
<b>Provider to Program</b>						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 141311

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

Worksheet E-1  
Part II  
Date/Time Prepared:  
11/22/2016 2:48 pm

Title XVIII

Hospital

Cost

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	722	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,566	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	2,505	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	72,141,094	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	16,300	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		Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part V Date/Time Prepared: 11/22/2016 2:48 pm
		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			2,721,816 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)			2,721,816 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,749,034 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)			2,749,034 19.00
20.00	Deductibles (exclude professional component)			493,202 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			2,255,832 22.00
23.00	Coinsurance			3,150 23.00
24.00	Subtotal (line 22 minus line 23)			2,252,682 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			84,689 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			55,048 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			70,053 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,307,730 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)			2,307,730 30.00
30.01	Sequestration adjustment (see instructions)			46,155 30.01
31.00	Interim payments			2,234,965 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)			26,610 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			61,411 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141311 Component CCN: 145552	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part VI Date/Time Prepared: 11/22/2016 2:48 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			0 1.00
2.00	Routine service other pass through costs			0 2.00
3.00	Ancillary service other pass through costs			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			0 4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible			0 6.00
7.00	Coinsurance			0 7.00
8.00	Allowable bad debts (see instructions)			0 8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0 9.00
10.00	Adjusted reimbursable bad debts (see instructions)			0 10.00
11.00	Utilization review			0 11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)			0 12.00
13.00	Inpatient primary payer payments			0 13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 14.50
14.99	Recovery of Accelerated Depreciation			0 14.99
15.00	Subtotal (see instructions)			0 15.00
15.01	Sequestration adjustment (see instructions)			0 15.01
16.00	Interim payments			0 16.00
17.00	Tentative settlement (for contractor use only)			0 17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)			0 18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2			0 19.00

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

Provider CCN: 141311

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

Worksheet G

Date/Time Prepared:  
11/22/2016 2:48 pm

		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	743,643	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	19,376,858	0	0	0	4.00
5.00	Other receivable	669,155	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,935,355	0	0	0	6.00
7.00	Inventory	376,118	0	0	0	7.00
8.00	Prepaid expenses	281,305	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)	9,511,724	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	38,015,625	0	0	0	15.00
16.00	Accumulated depreciation	-22,908,512	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	15,107,113	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	1,761	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	1,124,976	0	0	0	33.00
34.00	Other assets	1,062,010	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,188,747	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	26,807,584	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	1,757,397	0	0	0	37.00
38.00	Salaries, wages, and fees payable	442,570	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	584,144	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	1,794,556	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,578,667	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,482,242	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)	6,482,242	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,060,909	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	15,746,675				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)	15,746,675	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	26,807,584	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141311

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

Worksheet G-1

Date/Time Prepared:  
11/22/2016 2:48 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		14,825,659		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		909,129			2.00
3.00	Total (sum of line 1 and line 2)		15,734,788		0	3.00
4.00	OTHER	11,887		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)		11,887		0	10.00
11.00	Subtotal (line 3 plus line 10)		15,746,675		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)		15,746,675		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	OTHER		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: 141311

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/22/2016 2:48 pm

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	5,488,011		5,488,011	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,035,520		1,035,520	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,523,531		6,523,531	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	425,415		425,415	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)	425,415		425,415	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,948,946		6,948,946	17.00
18.00	Ancillary services	8,535,519	50,872,676	59,408,195	18.00
19.00	Outpatient services	0	953,843	953,843	19.00
20.00	RURAL HEALTH CLINIC	0	4,310,884	4,310,884	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		519,227	519,227	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	425,010	6,415,106	6,840,116	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	15,909,475	63,071,736	78,981,211	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,939,144		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	NON OPERATING EXPENSE	80,616			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)		80,616		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		28,858,528		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141311

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

Worksheet G-3

Date/Time Prepared:  
11/22/2016 2:48 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	78,981,211	1.00
2.00	Less contractual allowances and discounts on patients' accounts	50,268,940	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,712,271	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,858,528	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-146,257	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	910,490	24.00
24.01	NON OPERATING REVENUE	144,896	24.01
24.02		0	24.02
25.00	Total other income (sum of lines 6-24)	1,055,386	25.00
26.00	Total (line 5 plus line 25)	909,129	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	909,129	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141311

Period: From 07/01/2015

Worksheet H

HHA CCN: 147612

To 06/30/2016

Date/Time Prepared: 11/22/2016 2:48 pm

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	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	28,754	0	33,714	4,611	27,247	94,326	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	139,868	0	0	0	0	139,868	6.00
7.00	0	0	0	0	0	0	7.00
8.00	0	0	0	0	0	0	8.00
9.00	0	0	0	0	0	0	9.00
10.00	0	0	0	0	0	0	10.00
11.00	0	0	0	0	0	0	11.00
12.00	0	0	0	0	0	0	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	79,804	0	0	0	0	79,804	23.00
24.00	248,426	0	33,714	4,611	27,247	313,998	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	-1,753	92,573	0	92,573			5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	0	139,868	0	139,868			6.00
7.00	0	0	0	0			7.00
8.00	0	0	0	0			8.00
9.00	0	0	0	0			9.00
10.00	0	0	0	0			10.00
11.00	0	0	0	0			11.00
12.00	0	0	0	0			12.00
13.00	0	0	0	0			13.00
14.00	0	0	0	0			14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	79,804	0	79,804			23.00
24.00	-1,753	312,245	0	312,245			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 141311	Period: 07/01/2015	Worksheet H-1
		HHA CCN: 147612	To 06/30/2016	Part I
				Date/Time Prepared: 11/22/2016 2:48 pm
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	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bl dgs & Fixtures	Movable Equipment				
		1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0		0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	92,573	0	0	0	92,573	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	139,868	0	0	0	139,868	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	DIRECTOR	79,804	0	0	0	79,804	23.00
24.00	Total (sum of lines 1-23)	312,245	0	0	0	312,245	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	92,573					5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	58,942	198,810				6.00
7.00	Physical Therapy	0	0				7.00
8.00	Occupational Therapy	0	0				8.00
9.00	Speech Pathology	0	0				9.00
10.00	Medical Social Services	0	0				10.00
11.00	Home Health Aide	0	0				11.00
12.00	Supplies (see instructions)	0	0				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	DIRECTOR	33,631	113,435				23.00
24.00	Total (sum of lines 1-23)		312,245				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 141311

Period: From 07/01/2015

Worksheet H-1

HHA CCN: 147612

To 06/30/2016

Part II  
Date/Time Prepared:  
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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-92,573	219,672
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	0	0	0	0	139,868
7.00	Physical Therapy	0	0	0	0	0	0
8.00	Occupational Therapy	0	0	0	0	0	0
9.00	Speech Pathology	0	0	0	0	0	0
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	0	0	0	0	0	0
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	DIRECTOR	0	0	0	0	0	79,804
24.00	Total (sum of lines 1-23)	0	0	0	0	-92,573	219,672
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		92,573
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.421415

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141311

Period: From 07/01/2015

Worksheet H-2

HHA CCN: 147612

To 06/30/2016

Part I  
Date/Time Prepared:  
11/22/2016 2:48 pm

Home Health Agency I

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Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP				
		0	1.00				
1.00 Administrative and General	0	23,780	11,824	7,282	42,886	6,505	1.00
2.00 Skilled Nursing Care	198,810	0	0	35,423	234,233	35,527	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 DIRECTOR	113,435	0	0	20,211	133,646	20,271	19.00
20.00 Total (sum of lines 1-19) (2)	312,245	23,780	11,824	62,916	410,765	62,303	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
	6.00	7.00	8.00	9.00	10.00	11.00	
1.00 Administrative and General	21,020	18,086	0	17,370	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 DIRECTOR	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	21,020	18,086	0	17,370	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141311

Period: From 07/01/2015

Worksheet H-2 Part I

HHA CCN: 147612

To 06/30/2016

Date/Time Prepared: 11/22/2016 2:48 pm

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Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		13.00	16.00	17.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	0	105,867	0	105,867	1.00
2.00	Skilled Nursing Care	0	0	0	269,760	0	269,760	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	DIRECTOR	0	0	0	153,917	0	153,917	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	529,544	0	529,544	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							
2.00	Skilled Nursing Care	67,407	337,167					
3.00	Physical Therapy	0	0					
4.00	Occupational Therapy	0	0					
5.00	Speech Pathology	0	0					
6.00	Medical Social Services	0	0					
7.00	Home Health Aide	0	0					
8.00	Supplies (see instructions)	0	0					
9.00	Drugs	0	0					
10.00	DME	0	0					
11.00	Home Dialysis Aide Services	0	0					
12.00	Respiratory Therapy	0	0					
13.00	Private Duty Nursing	0	0					
14.00	Clinic	0	0					
15.00	Health Promotion Activities	0	0					
16.00	Day Care Program	0	0					
17.00	Home Delivered Meals Program	0	0					
18.00	Homemaker Service	0	0					
19.00	DIRECTOR	38,460	192,377					
20.00	Total (sum of lines 1-19) (2)	105,867	529,544					
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.249877						

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141311  
HHA CCN: 147612

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

Worksheet H-2  
Part II  
Date/Time Prepared:  
11/22/2016 2:48 pm  
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00					
1.00 Administrative and General	1,920	1,920	28,754	0	42,886	1,920	1.00
2.00 Skilled Nursing Care	0	0	139,868	0	234,233	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 DIRECTOR	0	0	79,804	0	133,646	0	19.00
20.00 Total (sum of lines 1-19)	1,920	1,920	248,426		410,765	1,920	20.00
21.00 Total cost to be allocated	23,780	11,824	62,916		62,303	21,020	21.00
22.00 Unit cost multiplier	12.385417	6.158333	0.253259		0.151676	10.947917	22.00
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PAID HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	1,920	0	1,920	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 DIRECTOR	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	1,920	0	1,920	0	0	0	20.00
21.00 Total cost to be allocated	18,086	0	17,370	0	0	0	21.00
22.00 Unit cost multiplier	9.419792	0.000000	9.046875	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141311  
HHA CCN: 147612

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

Worksheet H-2  
Part II  
Date/Time Prepared:  
11/22/2016 2:48 pm  
PPS

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)		
		16.00	17.00		
1.00	Administrative and General	0	0		1.00
2.00	Skilled Nursing Care	0	0		2.00
3.00	Physical Therapy	0	0		3.00
4.00	Occupational Therapy	0	0		4.00
5.00	Speech Pathology	0	0		5.00
6.00	Medical Social Services	0	0		6.00
7.00	Home Health Aide	0	0		7.00
8.00	Supplies (see instructions)	0	0		8.00
9.00	Drugs	0	0		9.00
10.00	DME	0	0		10.00
11.00	Home Dialysis Aide Services	0	0		11.00
12.00	Respiratory Therapy	0	0		12.00
13.00	Private Duty Nursing	0	0		13.00
14.00	Clinic	0	0		14.00
15.00	Health Promotion Activities	0	0		15.00
16.00	Day Care Program	0	0		16.00
17.00	Home Delivered Meals Program	0	0		17.00
18.00	Homemaker Service	0	0		18.00
19.00	DI DIRECTOR	0	0		19.00
20.00	Total (sum of lines 1-19)	0	0		20.00
21.00	Total cost to be allocated	0	0		21.00
22.00	Unit cost multiplier	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet H-3 Part I Date/Time Prepared: 11/22/2016 2:48 pm
		HHA CCN: 147612	Title XVIII	Home Health Agency I PPS

Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	337,167		337,167	1,867	180.59	1.00
2.00	Physical Therapy	3.00	0	0	0	882	0.00	2.00
3.00	Occupational Therapy	4.00	0	0	0	256	0.00	3.00
4.00	Speech Pathology	5.00	0	0	0	29	0.00	4.00
5.00	Medical Social Services	6.00	0	0	0	0	0.00	5.00
6.00	Home Health Aide	7.00	0	0	0	285	0.00	6.00
7.00	Total (sum of lines 1-6)		337,167	0	337,167	3,319		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits		Ratio (col. 3 ÷ col. 4)
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation							
8.00	Skilled Nursing Care		14999	0	1,571		8.00
9.00	Physical Therapy		14999	0	790		9.00
10.00	Occupational Therapy		14999	0	211		10.00
11.00	Speech Pathology		14999	0	25		11.00
12.00	Medical Social Services		14999	0	0		12.00
13.00	Home Health Aide		14999	0	1		13.00
14.00	Total (sum of lines 8-13)			0	2,598		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0.000000	16.00

Cost Center Description	Part A	Program Visits		Cost of Services	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
	6.00	7.00	8.00	9.00	10.00	11.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,571		0	283,707	1.00
2.00	Physical Therapy	0	790		0	0	2.00
3.00	Occupational Therapy	0	211		0	0	3.00
4.00	Speech Pathology	0	25		0	0	4.00
5.00	Medical Social Services	0	0		0	0	5.00
6.00	Home Health Aide	0	1		0	0	6.00
7.00	Total (sum of lines 1-6)	0	2,598		0	283,707	7.00

Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00
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Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS	Provider CCN: 141311	Period: From 07/01/2015	Worksheet H-3
	HHA CCN: 147612	To 06/30/2016	Part I Date/Time Prepared: 11/22/2016 2:48 pm
	Title XVII I	Home Health Agency I	PPS

Cost Center Description	Program Covered Charges			Cost of Services	Part B	Subject to Deductibles & Coinsurance		
	Part A	Part B						
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	6.00	7.00	8.00	9.00	10.00	11.00		
<b>Supplies and Drugs Cost Computations</b>								
15.00 Cost of Medical Supplies	0	0	0	0	0	0	15.00	
16.00 Cost of Drugs		0	0		0	0	16.00	
<b>Cost Center Description</b>								
	Total Program Cost (sum of col.s. 9-10)							
	12.00							
<b>PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION</b>								
<b>Cost Per Visit Computation</b>								
1.00 Skilled Nursing Care	283,707							1.00
2.00 Physical Therapy	0							2.00
3.00 Occupational Therapy	0							3.00
4.00 Speech Pathology	0							4.00
5.00 Medical Social Services	0							5.00
6.00 Home Health Aide	0							6.00
7.00 Total (sum of lines 1-6)	283,707							7.00
<b>Cost Center Description</b>								
	12.00							
<b>Limitation Cost Computation</b>								
8.00 Skilled Nursing Care								8.00
9.00 Physical Therapy								9.00
10.00 Occupational Therapy								10.00
11.00 Speech Pathology								11.00
12.00 Medical Social Services								12.00
13.00 Home Health Aide								13.00
14.00 Total (sum of lines 8-13)								14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 141311 HHA CCN: 147612	Period: From 07/01/2015 To 06/30/2016	Worksheet H-3 Part II Date/Time Prepared: 11/22/2016 2:48 pm
			Title XVIII	Home Health Agency I

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>						
1.00	Physical Therapy	66.00	0.407083	0	0	col. 2, line 2.00
2.00	Occupational Therapy					
3.00	Speech Pathology					
4.00	Cost of Medical Supplies	71.00	0.209025	0	0	col. 2, line 15.00
5.00	Cost of Drugs	73.00	0.297821	0	0	col. 2, line 16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 141311 HHA CCN: 147612	Period: From 07/01/2015 To 06/30/2016	Worksheet H-4 Part I-II Date/Time Prepared: 11/22/2016 2:48 pm
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
<b>PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES</b>				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
<b>PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT</b>				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	366,649
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	16,649
13.00	Total PPS Reimbursement - LUPA Episodes		0	6,835
14.00	Total PPS Reimbursement - PEP Episodes		0	930
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	9,360
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	400,423
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	400,423
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	400,423
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	400,423
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
31.00	Subtotal (see instructions)		0	400,423
31.01	Sequestration adjustment (see instructions)		0	8,009
32.00	Interim payments (see instructions)		0	392,414
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 141311  
HHA CCN: 147612

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

Worksheet H-5  
Date/Time Prepared:  
11/22/2016 2:48 pm  
PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		392,414	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		392,414	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		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		392,414	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2015 To 06/30/2016	Worksheet M-1 Date/Time Prepared: 11/22/2016 2:48 pm
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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)	
		1.00	2.00	3.00	4.00	5.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1.00	Physician	1,131,312	0	1,131,312	0	1,131,312	1.00
2.00	Physician Assistant	185,418	0	185,418	0	185,418	2.00
3.00	Nurse Practitioner	23,869	0	23,869	0	23,869	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	77,623	0	77,623	0	77,623	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)	1,418,222	0	1,418,222	0	1,418,222	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,418,222	0	1,418,222	0	1,418,222	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	0	0	0	0	29.00
30.00	Administrative Costs	789,375	332,511	1,121,886	-18,179	1,103,707	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	789,375	332,511	1,121,886	-18,179	1,103,707	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,207,597	332,511	2,540,108	-18,179	2,521,929	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2015 To 06/30/2016	Worksheet M-1 Date/Time Prepared: 11/22/2016 2:48 pm
		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	-141,704	989,608	1.00
2.00	Physician Assistant	0	185,418	2.00
3.00	Nurse Practitioner	0	23,869	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	77,623	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)	-141,704	1,276,518	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-141,704	1,276,518	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	0	29.00
30.00	Administrative Costs	0	1,103,707	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	1,103,707	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-141,704	2,380,225	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2015 To 06/30/2016	Worksheet M-2 Date/Time Prepared: 11/22/2016 2:48 pm
			Rural Health Clinic (RHC) I	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>VISITS AND PRODUCTIVITY</b>						
<b>Positions</b>						
1.00	Physician	3.44	15,806	4,200	14,448	1.00
2.00	Physician Assistant	1.39	4,964	2,100	2,919	2.00
3.00	Nurse Practitioner	0.22	249	2,100	462	3.00
4.00	Subtotal (sum of lines 1 through 3)	5.05	21,019		17,829	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	1.00	1,498		1,498	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	6.05	22,517		22,517	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)		1,276,518 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)		1,276,518 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)		1,103,707 14.00
15.00	Parent provider overhead allocated to facility (see instructions)		1,848,401 15.00
16.00	Total overhead (sum of lines 14 and 15)		2,952,108 16.00
17.00	Allowable GME overhead (see instructions)		0 17.00
18.00	Subtotal (see instructions)		2,952,108 18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)		2,952,108 19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		4,228,626 20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141311	Period: From 07/01/2015 To 06/30/2016	Worksheet M-3
		Component CCN: 148500		Date/Time Prepared: 11/22/2016 2:48 pm
		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)		4,228,626	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		279,910	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		3,948,716	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		22,517	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)		22,517	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		175.37	7.00
		<b>Calculation of Limit (1)</b>		
		<b>Prior to January 1</b>	<b>On or After January 1</b>	
		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)	175.37	175.37	9.00
<b>CALCULATION OF SETTLEMENT</b>				
10.00	Program covered visits excluding mental health services (from contractor records)	0	6,162	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,080,630	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	232	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	40,686	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	40,686	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) *		1,121,316	16.00
16.01	Total program charges (see instructions)(from contractor's records)		765,336	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,174	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		6,116	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.)		819,820	16.04
16.05	Total program cost (see instructions)		825,936	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		90,425	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		134,147	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		825,936	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		212,785	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,038,721	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		1,038,721	26.00
26.01	Sequestration adjustment (see instructions)		20,774	26.01
27.00	Interim payments		1,000,646	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)		17,301	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		24,775	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2015 To 06/30/2016	Worksheet M-4 Date/Time Prepared: 11/22/2016 2:48 pm
		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)	1,276,518	1,276,518	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.004389	0.004906	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	5,603	6,263	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	61,496	11,136	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	67,099	17,399	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,276,518	1,276,518	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	2,952,108	2,952,108	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.052564	0.013630	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	155,175	40,237	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	222,274	57,636	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	416	465	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	534.31	123.95	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	337	264	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	180,062	32,723	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)		279,910	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)		212,785	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2015 To 06/30/2016	Worksheet M-5 Date/Time Prepared: 11/22/2016 2:48 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		1,000,646	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)		1,000,646	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		17,301	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,017,947	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00