

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: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/20/2016 1:29 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: 11/20/2016 Time: 1:29 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 RED BUD REGIONAL HOSPITAL ( 141348 ) 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 V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	106,195	-1,442,717	3,393	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	-74,567	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		388,472		0	10.00
200.00 Total	0	31,628	-1,054,245	3,393	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/20/2016 1:26 pm
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1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 Zip Code: 62278-		4.00 County: RANDOLPH		1.00
1.00	Street: ST. CLEMENT BLVD	2.00 State: IL		3.00 Zip Code: 62278-		4.00 County: RANDOLPH		2.00
2.00	City: RED BUD	2.00 State: IL		3.00 Zip Code: 62278-		4.00 County: RANDOLPH		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		

3.00 Hospital and Hospital-Based Component Identification:										
3.00	Hospital	RED BUD REGIONAL HOSPITAL	141348	99914	1	07/01/2005	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	RED BUD HOSPITAL	14Z348	99914		08/10/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	OLDER ADULT HEALTH CENTER	148514	99914		05/26/2011	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)					4		21.00

22.00 Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					N	N	22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N	22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N	22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N	23.00	

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00	0	0	0	0	0	0	24.00
25.00	0	0	0	0	0	0	25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/20/2016 1:26 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	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
<b>Teaching Hospitals</b>							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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)							61.06		
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count					
	1.00	2.00	3.00	4.00						
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.						0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.						0.00	0.00	61.20	
						1.00				
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)						0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings										
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)						N	63.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))					
			1.00	2.00	3.00					
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))				
		1.00	2.00	3.00	4.00	5.00				
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						0.00	0.00	0.000000	65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
				1.00		
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00
<b>TEFRA Providers</b>						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N		87.00
				V	XIX	
				1.00	2.00	
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V		XIX			
		1.00	2.00	3.00	4.00		
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 1.00	Occupational 2.00	Speech 3.00	Respiratory 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.	1				118.00	
		Premiums 1.00	Losses 2.00	Insurance 3.00			
118.01	List amounts of malpractice premiums and paid losses:	15,177	22,142		0	118.01	
					1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
<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: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/20/2016 1:26 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		449008	140.00		
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: QUORUM HEALTH	Contractor's Name: WPS		Contractor's Number: 52280			
142.00	Street: 1573 MALLORY LANE SUITE 100	PO Box:					
143.00	City: BRENTWOOD	State: TN	Zip Code:	37027			
				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		
156.00	Subprovider - IPF	N	N	N	N		
157.00	Subprovider - IRF	N	N	N	N		
158.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC		N	N	N		
					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		
		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)					3,462	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/20/2016 1:26 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)		01/01/2015	03/31/2015	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: 141348		Period: From 07/01/2015 To 06/30/2016		Worksheet S-2 Part II Date/Time Prepared: 11/20/2016 1:26 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.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
					Y/N		
					1.00		
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	08/24/2016	Y	08/24/2016
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/20/2016 1:26 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.		Y		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?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2015	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.	MARK	SHROUT		41.00
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6152213660	MI CHAEL_TEA@CHS.NET		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 141348

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
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		3.00	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REVENUE MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141348

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/20/2016 1:26 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	45,867.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	45,867.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,150	45,867.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				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: 141348

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/20/2016 1:26 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,358	92	1,934			1.00
2.00 HMO and other (see instructions)	192	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	2,591	0	2,591			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	914			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	3,949	92	5,439			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)	3,949	92	5,439	0.00	131.29	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	4,882	0	10,977	0.00	16.80	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	148.09	27.00
28.00 Observation Bed Days		0	325			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: 141348

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/20/2016 1:26 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	393	41	581	1.00	
2.00 HMO and other (see instructions)			53	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	393	41	581	14.00	
15.00 CAH visits						15.00	
16.00 SUBPROVIDER - IPF						16.00	
17.00 SUBPROVIDER - IRF						17.00	
18.00 SUBPROVIDER						18.00	
19.00 SKILLED NURSING FACILITY						19.00	
20.00 NURSING FACILITY						20.00	
21.00 OTHER LONG TERM CARE						21.00	
22.00 HOME HEALTH AGENCY						22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00	
24.00 HOSPICE						24.00	
24.10 HOSPICE (non-distinct part)						24.10	
25.00 CMHC - CMHC						25.00	
26.00 RURAL HEALTH CLINIC	0.00					26.00	
26.25 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: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet S-3 Part IV Date/Time Prepared: 11/20/2016 1:26 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		184,169	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)		1,159,309	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		12,681	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		10,903	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)		13,033	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		28,549	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		541,136	17.00
18.00	Medicare Taxes - Employers Portion Only		126,556	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		59,895	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	Total Wage Related cost (Sum of lines 1 -23)		2,136,231	24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS		-13,842	25.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141348 Component CCN: 148514	Period: From 07/01/2015 To 06/30/2016	Worksheet S-8 Date/Time Prepared: 11/20/2016 1:26 pm Cost
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				1.00			
1.00	Clinic Address and Identification		Street			325 SPRING STREET	1.00
		City	State	ZIP Code			
		1.00	2.00	3.00			
2.00	City, State, ZIP Code, County		RED BUD	IL	62278	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	2.00		
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N	0	10.00
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11.00	Facility hours of operations (1)						
Clinic			08:00	05:00	08:00	11.00	
				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	Total Visits
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		RANDOLPH			2.00	
		Tuesday		Wednesday		Thursday	
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
11.00	Facility hours of operations (1)						
Clinic		05:00	08:00	05:00	08:00	05:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141348 Component CCN: 148514	Period: From 07/01/2015 To 06/30/2016	Worksheet S-8 Date/Time Prepared: 11/20/2016 1:26 pm Cost
		Rural Health Clinic (RHC) I	

	Friday		Saturday			
	from	to	from	to		
	11.00	11.00	12.00	13.00		
11.00	08:00	05:00				11.00

Facility hours of operations (1)  
Clinic

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet S-10 Date/Time Prepared: 11/20/2016 1:26 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)		0.173000	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		862,130	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		144,806	5.00	
6.00	Medicaid charges		12,228,276	6.00	
7.00	Medicaid cost (line 1 times line 6)		2,115,492	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)		1,108,556	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		13,115	9.00	
10.00	Stand-alone SCHIP charges		89,010	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		15,399	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		2,284	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		21,371	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,110,840	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	127,995	20,106	148,101	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	22,143	3,478	25,621	21.00
22.00	Partial payment by patients approved for charity care	1,837	0	1,837	22.00
23.00	Cost of charity care (line 21 minus line 22)	20,306	3,478	23,784	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)		1,281,911	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		435,411	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		846,500	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		146,445	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		170,229	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,281,069	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141348

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

Worksheet A  
Date/Time Prepared:  
11/20/2016 1:26 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS-BLDG & FIXT		317,804	317,804	36,646	354,450	1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		1,396,235	1,396,235	459,733	1,855,968	2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	121,856	70,718	192,574	1,244,828	1,437,402	4.00
5.00 00500 ADMINISTRATIVE & GENERAL	1,271,214	5,574,755	6,845,969	-1,510,878	5,335,091	5.00
7.00 00700 OPERATION OF PLANT	180,603	953,801	1,134,404	-48,540	1,085,864	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	80,679	80,679	0	80,679	8.00
9.00 00900 HOUSEKEEPING	167,747	49,470	217,217	-12,178	205,039	9.00
10.00 01000 DIETARY	0	803,591	803,591	-175,740	627,851	10.00
11.00 01100 CAFETERIA	0	0	0	175,740	175,740	11.00
13.00 01300 NURSING ADMINISTRATION	658,084	86,274	744,358	-66,626	677,732	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	34,401	298,979	333,380	-241,361	92,019	14.00
15.00 01500 PHARMACY	302,934	548,634	851,568	-496,921	354,647	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	249,989	113,714	363,703	-11,431	352,272	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	1,314,227	239,152	1,553,379	-9,020	1,544,359	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	407,720	149,834	557,554	-64,929	492,625	50.00
53.00 05300 ANESTHESIOLOGY	0	12,136	12,136	390,411	402,547	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	680,630	765,815	1,446,445	-290,811	1,155,634	54.00
60.00 06000 LABORATORY	441,877	526,172	968,049	-60,120	907,929	60.00
65.00 06500 RESPIRATORY THERAPY	105,882	45,087	150,969	-21,372	129,597	65.00
66.00 06600 PHYSICAL THERAPY	512,348	61,411	573,759	-2,276	571,483	66.00
67.00 06700 OCCUPATIONAL THERAPY	164,263	13,653	177,916	0	177,916	67.00
68.00 06800 SPEECH PATHOLOGY	4,290	43,443	47,733	0	47,733	68.00
69.00 06900 ELECTROCARDIOLOGY	25,221	16,165	41,386	0	41,386	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	193,561	193,561	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	107,041	107,041	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	476,365	476,365	73.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	26,317	249,826	276,143	0	276,143	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	1,171,957	635,172	1,807,129	-60,813	1,746,316	88.00
91.00 09100 EMERGENCY	1,178,441	984,134	2,162,575	-392,756	1,769,819	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00 SUBTOTALS (SUM OF LINES 1-117)	9,020,001	14,036,654	23,056,655	-381,447	22,675,208	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	-43,807	-43,807	0	-43,807	192.00
194.00 07950 HOME HEALTH	0	0	0	0	0	194.00
194.01 07951 MARKETING	0	0	0	119,969	119,969	194.01
194.02 07952 SENIOR CIRCLE	12,653	3,478	16,131	0	16,131	194.02
194.03 07953 RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04 07954 WATERLOO SPECIALTY CLINIC	0	221	221	0	221	194.04
194.05 07955 FREE STANDING NURSING HOME	0	0	0	261,478	261,478	194.05
194.06 07956 CLINIC CORPORATION	0	0	0	0	0	194.06
194.07 07957 VACANT SPACE	0	0	0	0	0	194.07
200.00 TOTAL (SUM OF LINES 118-199)	9,032,654	13,996,546	23,029,200	0	23,029,200	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141348

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

Worksheet A  
Date/Time Prepared:  
11/20/2016 1:26 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	191,222	545,672	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-294,817	1,561,151	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-65,802	1,371,600	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,627,016	3,708,075	5.00
7.00	00700	OPERATION OF PLANT	0	1,085,864	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	80,679	8.00
9.00	00900	HOUSEKEEPING	0	205,039	9.00
10.00	01000	DIETARY	476,772	1,104,623	10.00
11.00	01100	CAFETERIA	-1,711	174,029	11.00
13.00	01300	NURSING ADMINISTRATION	-356	677,376	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	92,019	14.00
15.00	01500	PHARMACY	0	354,647	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-20	352,252	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-158,301	1,386,058	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	492,625	50.00
53.00	05300	ANESTHESIOLOGY	-388,127	14,420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-46	1,155,588	54.00
60.00	06000	LABORATORY	-24,992	882,937	60.00
65.00	06500	RESPIRATORY THERAPY	0	129,597	65.00
66.00	06600	PHYSICAL THERAPY	0	571,483	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	177,916	67.00
68.00	06800	SPEECH PATHOLOGY	0	47,733	68.00
69.00	06900	ELECTROCARDIOLOGY	-20,847	20,539	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	193,561	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	107,041	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-123	476,242	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	276,143	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	-17	1,746,299	88.00
91.00	09100	EMERGENCY	-213,629	1,556,190	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,127,810	20,547,398	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-7	-7	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-43,807	192.00
194.00	07950	HOME HEALTH	0	0	194.00
194.01	07951	MARKETING	0	119,969	194.01
194.02	07952	SENIOR CIRCLE	-589	15,542	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	62,533	62,754	194.04
194.05	07955	FREE STANDING NURSING HOME	0	261,478	194.05
194.06	07956	CLINIC CORPORATION	0	0	194.06
194.07	07957	VACANT SPACE	0	0	194.07
200.00		TOTAL (SUM OF LINES 118-199)	-2,065,873	20,963,327	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - EMPLOYEE BENEFITS</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,290,214	1.00
	O		0	1,290,214	
<b>B - OXYGEN COSTS</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	8,375	1.00
	O		0	8,375	
<b>C - DEFAULT</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	452,062	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
	O		0	452,062	
<b>D - OTHER CAPITAL COSTS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	37,643	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,671	2.00
3.00		0.00	0	0	3.00
	O		0	45,314	
<b>E - MARKETING COSTS</b>					
1.00	MARKETING	194.01	29,507	90,462	1.00
	O		29,507	90,462	
<b>F - MEDICAL SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	184,545	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	107,041	2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	641	3.00
	O		0	292,227	
<b>G - RECLASS COST OF DRUGS/IV SOLUTIONS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	476,365	1.00
	O		0	476,365	
<b>H - CAFETERIA COSTS</b>					
1.00	CAFETERIA	11.00	0	175,740	1.00
	O		0	175,740	
<b>I - ALLOCATE NURSING HOME COSTS</b>					
1.00	FREE STANDING NURSING HOME	194.05	250,719	10,759	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
	O		250,719	10,759	
<b>J - ALLOCATED CLINIC COSTS</b>					
1.00	RURAL HEALTH CLINIC	88.00	6,742	539	1.00
	O		6,742	539	
<b>K - RECLASS ANESTHESIA COSTS</b>					
1.00	ANESTHESIOLOGY	53.00	388,127	2,438	1.00
	O		388,127	2,438	
<b>L - RECLASS MALPRACTICE EXPENSE</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	68,094	1.00
2.00		0.00	0	0	2.00
	O		0	68,094	
500.00	Grand Total: Increases		675,095	2,912,589	500.00

RECLASSIFICATIONS

Provider CCN: 141348

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

Worksheet A-6

Date/Time Prepared:  
11/20/2016 1:26 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
<b>A - EMPLOYEE BENEFITS</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,290,214	0	1.00
	O		0	1,290,214		
<b>B - OXYGEN COSTS</b>						
1.00	RESPIRATORY THERAPY	65.00	0	8,375	0	1.00
	O		0	8,375		
<b>C - DEFAULT</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	30,768	10	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	9,020	0	2.00
3.00	OPERATING ROOM	50.00	0	8,223	0	3.00
4.00	ANESTHESIOLOGY	53.00	0	154	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,840	0	5.00
6.00	LABORATORY	60.00	0	60,120	0	6.00
7.00	PHARMACY	15.00	0	20,556	0	7.00
8.00	RESPIRATORY THERAPY	65.00	0	12,997	0	8.00
9.00	PHYSICAL THERAPY	66.00	0	2,276	0	9.00
10.00	EMERGENCY	91.00	0	2,191	0	10.00
11.00	HOUSEKEEPING	9.00	0	447	0	11.00
12.00	OPERATION OF PLANT	7.00	0	1,028	0	12.00
13.00	NURSING ADMINISTRATION	13.00	0	156	0	13.00
14.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,435	0	14.00
15.00	MEDICAL RECORDS & LIBRARY	16.00	0	5,040	0	15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	290,811	0	16.00
	O		0	452,062		
<b>D - OTHER CAPITAL COSTS</b>						
1.00		0.00	0	0	12	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	44,317	12	2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	997	13	3.00
	O		0	45,314		
<b>E - MARKETING COSTS</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	29,507	90,462	0	1.00
	O		29,507	90,462		
<b>F - MEDICAL SUPPLIES</b>						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	235,521	0	1.00
2.00	OPERATING ROOM	50.00	0	56,706	0	2.00
3.00		0.00	0	0	0	3.00
	O		0	292,227		
<b>G - RECLASS COST OF DRUGS/IV SOLUTIONS</b>						
1.00	PHARMACY	15.00	0	476,365	0	1.00
	O		0	476,365		
<b>H - CAFETERIA COSTS</b>						
1.00	DIETARY	10.00	0	175,740	0	1.00
	O		0	175,740		
<b>I - ALLOCATE NURSING HOME COSTS</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	39,843	3,108	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	91,232	2,472	0	2.00
3.00	OPERATION OF PLANT	7.00	44,066	3,446	0	3.00
4.00	HOUSEKEEPING	9.00	11,731	0	0	4.00
5.00	NURSING ADMINISTRATION	13.00	57,456	1,733	0	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	6,391	0	0	6.00
	O		250,719	10,759		
<b>J - ALLOCATED CLINIC COSTS</b>						
1.00	NURSING ADMINISTRATION	13.00	6,742	539	0	1.00
	O		6,742	539		
<b>K - RECLASS ANESTHESIA COSTS</b>						
1.00	EMERGENCY	91.00	388,127	2,438	0	1.00
	O		388,127	2,438		
<b>L - RECLASS MALPRACTICE EXPENSE</b>						
1.00		0.00	0	0	0	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	68,094	0	2.00
	O		0	68,094		
500.00	Grand Total: Decreases		675,095	2,912,589		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141348

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
11/20/2016 1:26 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	311,428	0	0	0	0	2.00
3.00	Buildings and Fixtures	5,077,612	4,578	0	4,578	1,385	3.00
4.00	Building Improvements	6,813,916	603,586	0	603,586	166,338	4.00
5.00	Fixed Equipment	2,324,112	42,609	0	42,609	0	5.00
6.00	Movable Equipment	8,585,423	365,706	0	365,706	5,977	6.00
7.00	HIT designated Assets	3,102,500	3,462	0	3,462	0	7.00
8.00	Subtotal (sum of lines 1-7)	26,214,991	1,019,941	0	1,019,941	173,700	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	26,214,991	1,019,941	0	1,019,941	173,700	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	0	0				1.00
2.00	Land Improvements	311,428	0				2.00
3.00	Buildings and Fixtures	5,080,805	0				3.00
4.00	Building Improvements	7,251,164	0				4.00
5.00	Fixed Equipment	2,366,721	0				5.00
6.00	Movable Equipment	8,945,152	0				6.00
7.00	HIT designated Assets	3,105,962	0				7.00
8.00	Subtotal (sum of lines 1-7)	27,061,232	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	27,061,232	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141348

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
11/20/2016 1:26 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	317,804	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,396,235	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,714,039	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	317,804				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,396,235				2.00
3.00	Total (sum of lines 1-2)	0	1,714,039				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141348

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
11/20/2016 1:26 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	14,861,118	0	14,861,118	0.552207	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12,051,115	0	12,051,115	0.447793	0	2.00
3.00	Total (sum of lines 1-2)	26,912,233	0	26,912,233	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	496,631	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,051,502	452,062	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,548,133	452,062	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	37,643	-997	12,395	545,672	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	7,671	0	49,916	1,561,151	2.00
3.00	Total (sum of lines 1-2)	0	45,314	-997	62,311	2,106,823	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141348

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

Worksheet A-8

Date/Time Prepared:  
11/20/2016 1:26 pm

Line #	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	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-15,710		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-5,090		CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)			0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-417,769				0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-1,333		CAP REL COSTS-MVBLE EQUIP	2.00	9	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-905,830				0	12.00
13.00	Laundry and linen service			0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,711		CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others			0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-123		DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-20		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00	Vending machines	B	-7		GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	173,700		CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-334,454		CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00	TELEPHONE SERVICES	A	-77		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
35.00 RENTAL INCOME - SBC & RB SPEC CLINIC	B	-41,821	CAP REL COSTS-BLDG & FIXT	1.00	9 35.00
36.00 OTHER MISC REVENUE	B	-8,841	ADMINISTRATIVE & GENERAL	5.00	0 36.00
37.00 TELEPHONE SERVICES	A	-46	RADIOLOGY-DIAGNOSTIC	54.00	0 37.00
38.00 TELEPHONE SERVICES	A	-667	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 38.00
38.01 TELEPHONE SERVICES	A	-29	WATERLOO SPECIALTY CLINIC	194.04	0 38.01
38.02 TELEPHONE SERVICES	A	-17	RURAL HEALTH CLINIC	88.00	0 38.02
38.03 TELEPHONE SERVICES	A	-356	NURSING ADMINISTRATION	13.00	0 38.03
38.04 TELEPHONE DEPRECIATION	A	-3,856	CAP REL COSTS-MVBLE EQUIP	2.00	9 38.04
39.00 ADVERTISING	A	-36,459	ADMINISTRATIVE & GENERAL	5.00	0 39.00
39.01		0		0.00	0 39.01
41.00 PHYSICIAN RECRUITING	A	-10,346	ADMINISTRATIVE & GENERAL	5.00	0 41.00
42.00 LOBBYING EXPENSE IN ASSOCIATION DUES	A	-11,406	ADMINISTRATIVE & GENERAL	5.00	0 42.00
44.00 SPECIAL EVENTS	A	-4,025	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 44.00
45.00 SPECIAL EVENT	A	-589	SENIOR CIRCLE	194.02	0 45.00
45.01 CRNA COSTS	A	-388,127	ANESTHESIOLOGY	53.00	0 45.01
45.02 CRNA BENEFITS	A	-61,033	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 45.02
45.03 ILLINOIS PROVIDER TAX	A	-600,641	ADMINISTRATIVE & GENERAL	5.00	0 45.03
45.04 ADD BACK NH CREDIT FOR DIETARY	A	476,772	DIETARY	10.00	0 45.04
45.06 LEGAL FEES	A	71,526	ADMINISTRATIVE & GENERAL	5.00	0 45.06
45.07 CHARITABLE CONTRIBUTIONS	A	-50	ADMINISTRATIVE & GENERAL	5.00	0 45.07
45.08 REMOVAL OF LEASE REVENUE	A	62,562	WATERLOO SPECIALTY CLINIC	194.04	0 45.08
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,065,873			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: 141348

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

Worksheet A-8-1

Date/Time Prepared:  
11/20/2016 1:26 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DIRECT CAPITAL INTEREST	46,948	0
2.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	112,867	0
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COST	8,781	0
4.00	1.00	CAP REL COSTS-BLDG & FIXT	POOLED CAPITAL	3,614	0
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	POOLED CAPITAL	49,916	0
4.02	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	600,840	821,080
4.03	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	37,319	-547,862
4.04	5.00	ADMINISTRATIVE & GENERAL	INTEREST	0	1,717,559
4.05	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICE CENTER/QHC CO	224,662	0
4.06	0.00			0	0
4.07	0.00			0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,084,947	1,990,777

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

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

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

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

6.00	B	QHR	100.00	QUORUM HEALTH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 141348

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

Worksheet A-8-1

Date/Time Prepared:  
11/20/2016 1:26 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	46,948	9		1.00
2.00	112,867	0		2.00
3.00	8,781	14		3.00
4.00	3,614	14		4.00
4.01	49,916	14		4.01
4.02	-220,240	0		4.02
4.03	585,181	0		4.03
4.04	-1,717,559	0		4.04
4.05	224,662	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
5.00	-905,830			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		

**B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:**

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

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

6.00	HOSPITAL MANAGEMENT COMPA		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: 141348

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

Worksheet A-8-2

Date/Time Prepared:  
11/20/2016 1:26 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	158,301	158,301	0	0	0	1.00
2.00	60.00	LABORATORY	69,992	24,992	0	0	0	2.00
3.00	88.00	RURAL HEALTH CLINIC	758,672	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	20,847	20,847	0	0	0	4.00
5.00	91.00	EMERGENCY	436,833	213,629	223,204	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,444,645	417,769	223,204			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	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	88.00	RURAL HEALTH CLINIC	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	158,301	1.00
2.00	60.00	LABORATORY	0	0	0	24,992	2.00
3.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	20,847	4.00
5.00	91.00	EMERGENCY	0	0	0	213,629	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	417,769	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141348

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/20/2016 1:26 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	545,672	545,672			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,561,151		1,561,151		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,371,600	4,900	15,023	1,391,523	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,708,075	92,675	284,121	178,860	5.00
7.00 00700	OPERATION OF PLANT	1,085,864	133,162	408,241	21,227	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	80,679	1,213	3,719	0	8.00
9.00 00900	HOUSEKEEPING	205,039	8,403	25,762	24,255	9.00
10.00 01000	DIETARY	1,104,623	23,407	71,761	0	10.00
11.00 01100	CAFETERIA	174,029	12,227	37,484	0	11.00
13.00 01300	NURSING ADMINISTRATION	677,376	9,783	29,993	92,329	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	92,019	5,019	15,387	5,348	14.00
15.00 01500	PHARMACY	354,647	6,359	19,497	47,096	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	352,252	11,998	36,783	37,871	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	1,386,058	52,449	160,796	204,320	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	492,625	33,546	102,845	63,387	50.00
53.00 05300	ANESTHESIOLOGY	14,420	919	2,816	60,341	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,155,588	21,803	66,843	105,815	54.00
60.00 06000	LABORATORY	882,937	12,666	38,831	68,697	60.00
65.00 06500	RESPIRATORY THERAPY	129,597	2,698	8,273	16,461	65.00
66.00 06600	PHYSICAL THERAPY	571,483	17,747	54,407	79,653	66.00
67.00 06700	OCCUPATIONAL THERAPY	177,916	2,180	6,683	25,537	67.00
68.00 06800	SPEECH PATHOLOGY	47,733	0	0	667	68.00
69.00 06900	ELECTROCARDIOLOGY	20,539	4,338	13,299	3,921	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	193,561	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	107,041	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	476,242	0	0	0	73.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	276,143	4,738	14,525	4,091	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	1,746,299	25,099	76,949	183,248	88.00
91.00 09100	EMERGENCY	1,556,190	12,227	37,484	122,867	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	20,547,398	499,556	1,531,522	1,345,991	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-7	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	-43,807	36,451	0	0	192.00
194.00 07950	HOME HEALTH	0	0	0	0	194.00
194.01 07951	MARKETING	119,969	1,903	5,834	4,587	194.01
194.02 07952	SENIOR CIRCLE	15,542	752	2,304	1,967	194.02
194.03 07953	RED BUD SPECIALTY CLINIC	0	0	0	0	194.03
194.04 07954	WATERLOO SPECIALTY CLINIC	62,754	0	0	0	194.04
194.05 07955	FREE STANDING NURSING HOME	261,478	0	0	38,978	194.05
194.06 07956	CLINIC CORPORATION	0	0	0	0	194.06
194.07 07957	VACANT SPACE	0	7,010	21,491	0	194.07
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	20,963,327	545,672	1,561,151	1,391,523	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141348

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

Worksheet B  
Part I  
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11/20/2016 1:26 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	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	4,263,731					5.00
7.00	00700	430,056	2,078,550				7.00
8.00	00800	22,334	8,006	115,951			8.00
9.00	00900	68,731	55,460	8,601	396,251		9.00
10.00	01000	312,999	154,487	4,228	30,379	1,701,884	10.00
11.00	01100	58,369	80,695	0	15,868	0	11.00
13.00	01300	211,176	64,568	0	12,697	0	13.00
14.00	01400	30,724	33,125	0	6,514	0	14.00
15.00	01500	111,551	41,972	0	8,253	0	15.00
16.00	01600	114,500	79,187	0	15,571	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	470,526	346,156	43,287	68,069	379,862	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	180,633	221,404	12,046	43,537	0	50.00
53.00	05300	20,478	6,062	0	1,192	0	53.00
54.00	05400	352,198	143,899	15,915	28,297	0	54.00
60.00	06000	261,695	83,596	85	16,438	0	60.00
65.00	06500	40,965	17,810	0	3,502	0	65.00
66.00	06600	188,690	117,127	8,104	23,032	0	66.00
67.00	06700	55,389	14,387	0	2,829	0	67.00
68.00	06800	12,626	0	0	0	0	68.00
69.00	06900	10,982	28,629	1,050	5,630	0	69.00
71.00	07100	50,496	0	0	0	0	71.00
72.00	07200	27,925	0	0	0	0	72.00
73.00	07300	124,241	0	0	0	0	73.00
76.00	03550	78,132	31,269	0	6,149	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	530,005	165,654	176	32,575	0	88.00
91.00	09100	450,998	80,695	21,300	15,868	0	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		4,216,419	1,774,188	114,792	336,400	379,862	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	240,577	415	47,308	38,743	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	34,512	12,560	0	2,470	0	194.01
194.02	07952	5,365	4,960	744	975	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	1,283,279	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	7,435	46,265	0	9,098	0	194.07
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		4,263,731	2,078,550	115,951	396,251	1,701,884	202.00



COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141348

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/20/2016 1:26 pm

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
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	3,576,141	0	3,576,141	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	1,317,639	0	1,317,639	50.00
53.00	05300	215,207	0	215,207	53.00
54.00	05400	2,138,239	0	2,138,239	54.00
60.00	06000	1,586,451	0	1,586,451	60.00
65.00	06500	260,971	0	260,971	65.00
66.00	06600	1,238,986	0	1,238,986	66.00
67.00	06700	339,229	0	339,229	67.00
68.00	06800	63,007	0	63,007	68.00
69.00	06900	103,446	0	103,446	69.00
71.00	07100	305,447	0	305,447	71.00
72.00	07200	165,266	0	165,266	72.00
73.00	07300	1,292,177	0	1,292,177	73.00
76.00	03550	417,680	0	417,680	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	3,103,513	0	3,103,513	88.00
91.00	09100	2,564,348	0	2,564,348	91.00
92.00	09200		0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		18,687,747	0	18,687,747	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	-7	0	-7	190.00
192.00	19200	321,064	0	321,064	192.00
194.00	07950	0	0	0	194.00
194.01	07951	183,375	0	183,375	194.01
194.02	07952	33,360	0	33,360	194.02
194.03	07953	0	0	0	194.03
194.04	07954	62,754	0	62,754	194.04
194.05	07955	1,583,735	0	1,583,735	194.05
194.06	07956	0	0	0	194.06
194.07	07957	91,299	0	91,299	194.07
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		20,963,327	0	20,963,327	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 11/20/2016 1:26 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,900	15,023	19,923	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	92,675	284,121	376,796	5.00
7.00 00700	OPERATION OF PLANT	0	133,162	408,241	541,403	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	1,213	3,719	4,932	8.00
9.00 00900	HOUSEKEEPING	0	8,403	25,762	34,165	9.00
10.00 01000	DIETARY	0	23,407	71,761	95,168	10.00
11.00 01100	CAFETERIA	0	12,227	37,484	49,711	11.00
13.00 01300	NURSING ADMINISTRATION	0	9,783	29,993	39,776	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	5,019	15,387	20,406	14.00
15.00 01500	PHARMACY	0	6,359	19,497	25,856	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	11,998	36,783	48,781	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	52,449	160,796	213,245	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	33,546	102,845	136,391	50.00
53.00 05300	ANESTHESIOLOGY	0	919	2,816	3,735	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	21,803	66,843	88,646	54.00
60.00 06000	LABORATORY	0	12,666	38,831	51,497	60.00
65.00 06500	RESPIRATORY THERAPY	0	2,698	8,273	10,971	65.00
66.00 06600	PHYSICAL THERAPY	0	17,747	54,407	72,154	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	2,180	6,683	8,863	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	4,338	13,299	17,637	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	4,738	14,525	19,263	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	25,099	76,949	102,048	88.00
91.00 09100	EMERGENCY	0	12,227	37,484	49,711	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	499,556	1,531,522	2,031,078	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	36,451	0	36,451	192.00
194.00 07950	HOME HEALTH	0	0	0	0	194.00
194.01 07951	MARKETING	0	1,903	5,834	7,737	194.01
194.02 07952	SENIOR CIRCLE	0	752	2,304	3,056	194.02
194.03 07953	RED BUD SPECIALTY CLINIC	0	0	0	0	194.03
194.04 07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	194.04
194.05 07955	FREE STANDING NURSING HOME	0	0	0	0	194.05
194.06 07956	CLINIC CORPORATION	0	0	0	0	194.06
194.07 07957	VACANT SPACE	0	7,010	21,491	28,501	194.07
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	545,672	1,561,151	2,106,823	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 11/20/2016 1:26 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	379,357				5.00	
7.00	00700	OPERATION OF PLANT	38,263	579,970			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	1,987	2,234	9,153		8.00	
9.00	00900	HOUSEKEEPING	6,115	15,475	679	56,781	9.00	
10.00	01000	DIETARY	27,848	43,106	334	4,353	170,809	10.00
11.00	01100	CAFETERIA	5,193	22,516	0	2,274	0	11.00
13.00	01300	NURSING ADMINISTRATION	18,789	18,016	0	1,819	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,734	9,243	0	933	0	14.00
15.00	01500	PHARMACY	9,925	11,711	0	1,183	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,187	22,095	0	2,231	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	41,864	96,589	3,416	9,753	38,125	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	16,071	61,777	951	6,239	0	50.00
53.00	05300	ANESTHESIOLOGY	1,822	1,692	0	171	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,336	40,152	1,256	4,055	0	54.00
60.00	06000	LABORATORY	23,284	23,325	7	2,356	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,645	4,969	0	502	0	65.00
66.00	06600	PHYSICAL THERAPY	16,788	32,681	640	3,300	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,928	4,014	0	405	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,123	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	977	7,988	83	807	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,493	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,485	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,054	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,952	8,725	0	881	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	47,158	46,222	14	4,668	0	88.00
91.00	09100	EMERGENCY	40,126	22,516	1,681	2,274	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	375,147	495,046	9,061	48,204	38,125	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	67,127	33	6,779	3,888	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	3,071	3,504	0	354	0	194.01
194.02	07952	SENIOR CIRCLE	477	1,384	59	140	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	128,796	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	662	12,909	0	1,304	0	194.07
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)	379,357	579,970	9,153	56,781	170,809	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 141348		Period: From 07/01/2015 To 06/30/2016		Worksheet B Part II Date/Time Prepared: 11/20/2016 1:26 pm	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
<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						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	79,694					11.00
13.00	01300	NURSING ADMINISTRATION	5,468	85,190				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	942	0	34,335			14.00
15.00	01500	PHARMACY	1,850	4,993	339	56,531		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,075	0	107	0	88,018	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	18,631	21,659	4,073	0	8,892	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	4,349	6,720	275	0	7,479	50.00
53.00	05300	ANESTHESIOLOGY	4,533	6,397	238	0	225	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,342	0	2,265	0	25,746	54.00
60.00	06000	LABORATORY	6,199	0	8,862	0	18,756	60.00
65.00	06500	RESPIRATORY THERAPY	1,406	1,745	272	0	1,375	65.00
66.00	06600	PHYSICAL THERAPY	5,127	8,445	155	0	5,548	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,638	2,707	2	0	1,422	67.00
68.00	06800	SPEECH PATHOLOGY	20	71	0	0	125	68.00
69.00	06900	ELECTROCARDIOLOGY	375	0	5	0	1,746	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	8,185	0	2,039	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,722	0	502	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	56,531	3,394	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	335	0	6	0	133	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	11,544	19,427	2,833	0	2,170	88.00
91.00	09100	EMERGENCY	4,157	13,026	1,937	0	8,466	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	78,991	85,190	34,276	56,531	88,018	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	287	0	3	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	266	0	49	0	0	194.01
194.02	07952	SENIOR CIRCLE	150	0	7	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
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)	79,694	85,190	34,335	56,531	88,018	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141348

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

Worksheet B  
Part II  
Date/Time Prepared:  
11/20/2016 1:26 pm

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
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	459,170	0	459,170	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	241,160	0	241,160	50.00
53.00	05300	19,677	0	19,677	53.00
54.00	05400	203,313	0	203,313	54.00
60.00	06000	135,270	0	135,270	60.00
65.00	06500	25,121	0	25,121	65.00
66.00	06600	145,978	0	145,978	66.00
67.00	06700	24,345	0	24,345	67.00
68.00	06800	1,349	0	1,349	68.00
69.00	06900	29,674	0	29,674	69.00
71.00	07100	14,717	0	14,717	71.00
72.00	07200	7,709	0	7,709	72.00
73.00	07300	70,979	0	70,979	73.00
76.00	03550	36,354	0	36,354	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	238,708	0	238,708	88.00
91.00	09100	145,653	0	145,653	91.00
92.00	09200		0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		1,799,177	0	1,799,177	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	0	0	0	190.00
192.00	19200	114,568	0	114,568	192.00
194.00	07950	0	0	0	194.00
194.01	07951	15,047	0	15,047	194.01
194.02	07952	5,301	0	5,301	194.02
194.03	07953	0	0	0	194.03
194.04	07954	0	0	0	194.04
194.05	07955	129,354	0	129,354	194.05
194.06	07956	0	0	0	194.06
194.07	07957	43,376	0	43,376	194.07
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		2,106,823	0	2,106,823	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141348

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

Worksheet B-1

Date/Time Prepared: 11/20/2016 1:26 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	124,160				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		115,866			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,115	1,115	8,950,641		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	21,087	21,087	1,150,475	-4,263,731	16,343,749
7.00 00700	OPERATION OF PLANT	30,299	30,299	136,537	0	1,648,494
8.00 00800	LAUNDRY & LINEN SERVICE	276	276	0	0	85,611
9.00 00900	HOUSEKEEPING	1,912	1,912	156,016	0	263,459
10.00 01000	DIETARY	5,326	5,326	0	0	1,199,791
11.00 01100	CAFETERIA	2,782	2,782	0	0	223,740
13.00 01300	NURSING ADMINISTRATION	2,226	2,226	593,886	0	809,481
14.00 01400	CENTRAL SERVICES & SUPPLY	1,142	1,142	34,401	0	117,773
15.00 01500	PHARMACY	1,447	1,447	302,934	0	427,599
16.00 01600	MEDICAL RECORDS & LIBRARY	2,730	2,730	243,598	0	438,904
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	11,934	11,934	1,314,227	0	1,803,623
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	7,633	7,633	407,720	0	692,403
53.00 05300	ANESTHESIOLOGY	209	209	388,127	0	78,496
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,961	4,961	680,630	0	1,350,049
60.00 06000	LABORATORY	2,882	2,882	441,877	0	1,003,131
65.00 06500	RESPIRATORY THERAPY	614	614	105,882	0	157,029
66.00 06600	PHYSICAL THERAPY	4,038	4,038	512,348	0	723,290
67.00 06700	OCCUPATIONAL THERAPY	496	496	164,263	0	212,316
68.00 06800	SPEECH PATHOLOGY	0	0	4,290	0	48,400
69.00 06900	ELECTROCARDIOLOGY	987	987	25,221	0	42,097
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	193,561
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	107,041
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	476,242
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,078	1,078	26,317	0	299,497
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	5,711	5,711	1,178,699	0	2,031,595
91.00 09100	EMERGENCY	2,782	2,782	790,314	0	1,728,768
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	113,667	113,667	8,657,762	-4,263,731	16,162,390
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	8,294	0	0	7,356	0
194.00 07950	HOME HEALTH	0	0	0	0	0
194.01 07951	MARKETING	433	433	29,507	0	132,293
194.02 07952	SENIOR CIRCLE	171	171	12,653	0	20,565
194.03 07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0
194.04 07954	WATERLOO SPECIALTY CLINIC	0	0	0	-62,754	0
194.05 07955	FREE STANDING NURSING HOME	0	0	250,719	-300,456	0
194.06 07956	CLINIC CORPORATION	0	0	0	0	0
194.07 07957	VACANT SPACE	1,595	1,595	0	0	28,501
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	545,672	1,561,151	1,391,523		4,263,731
203.00	Unit cost multiplier (Wkst. B, Part I)	4.394910	13.473763	0.155466		0.260878
204.00	Cost to be allocated (per Wkst. B, Part II)			19,923		379,357
205.00	Unit cost multiplier (Wkst. B, Part II)			0.002226		0.023211

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141348

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

Worksheet B-1

Date/Time Prepared:  
11/20/2016 1:26 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FULL TIME EQUIVALENT)	
		7.00	8.00	9.00	10.00	11.00	
<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					5.00
7.00	00700	OPERATION OF PLANT	71,659				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	276	141,485			8.00
9.00	00900	HOUSEKEEPING	1,912	10,495	69,471		9.00
10.00	01000	DIETARY	5,326	5,159	5,326	126,115	10.00
11.00	01100	CAFETERIA	2,782	0	2,782	0	11,674
13.00	01300	NURSING ADMINISTRATION	2,226	0	2,226	0	801
14.00	01400	CENTRAL SERVICES & SUPPLY	1,142	0	1,142	0	138
15.00	01500	PHARMACY	1,447	0	1,447	0	271
16.00	01600	MEDICAL RECORDS & LIBRARY	2,730	0	2,730	0	597
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	11,934	52,818	11,934	28,149	2,729
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	7,633	14,699	7,633	0	637
53.00	05300	ANESTHESIOLOGY	209	0	209	0	664
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,961	19,420	4,961	0	1,222
60.00	06000	LABORATORY	2,882	104	2,882	0	908
65.00	06500	RESPIRATORY THERAPY	614	0	614	0	206
66.00	06600	PHYSICAL THERAPY	4,038	9,889	4,038	0	751
67.00	06700	OCCUPATIONAL THERAPY	496	0	496	0	240
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	3
69.00	06900	ELECTROCARDIOLOGY	987	1,281	987	0	55
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,078	0	1,078	0	49
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	5,711	215	5,711	0	1,691
91.00	09100	EMERGENCY	2,782	25,991	2,782	0	609
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	61,166	140,071	58,978	28,149	11,571
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,294	506	8,294	2,871	42
194.00	07950	HOME HEALTH	0	0	0	0	0
194.01	07951	MARKETING	433	0	433	0	39
194.02	07952	SENIOR CIRCLE	171	908	171	0	22
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0
194.05	07955	FREE STANDING NURSING HOME	0	0	0	95,095	0
194.06	07956	CLINIC CORPORATION	0	0	0	0	0
194.07	07957	VACANT SPACE	1,595	0	1,595	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	2,078,550	115,951	396,251	1,701,884	378,672
203.00		Unit cost multiplier (Wkst. B, Part I)	29.006126	0.819529	5.703833	13.494699	32.437211
204.00		Cost to be allocated (per Wkst. B, Part II)	579,970	9,153	56,781	170,809	79,694
205.00		Unit cost multiplier (Wkst. B, Part II)	8.093470	0.064692	0.817334	1.354391	6.826623

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141348

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

Worksheet B-1

Date/Time Prepared:  
11/20/2016 1:26 pm

Cost Center Description		NURSING ADMINISTRATION (NURSING SALARY)	CENTRAL SERVICES & SUPPLY (COSTED REQUIRE)	PHARMACY (COSTED REQUIRE)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
		13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	5,168,804				13.00
14.00	01400	0	782,967			14.00
15.00	01500	302,934	7,728	476,365		15.00
16.00	01600	0	2,430	0	108,021,907	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	1,314,227	92,882	0	10,910,194	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	407,720	6,273	0	9,176,210	50.00
53.00	05300	388,127	5,435	0	276,508	53.00
54.00	05400	0	51,642	0	31,613,813	54.00
60.00	06000	0	202,105	0	23,012,953	60.00
65.00	06500	105,882	6,203	0	1,686,925	65.00
66.00	06600	512,348	3,539	0	6,807,938	66.00
67.00	06700	164,263	52	0	1,744,995	67.00
68.00	06800	4,290	0	0	153,687	68.00
69.00	06900	0	109	0	2,141,771	69.00
71.00	07100	0	186,647	0	2,501,863	71.00
72.00	07200	0	107,683	0	615,991	72.00
73.00	07300	0	0	476,365	4,164,662	73.00
76.00	03550	0	131	0	163,600	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	1,178,699	64,600	0	2,662,659	88.00
91.00	09100	790,314	44,180	0	10,388,138	91.00
92.00	09200					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		5,168,804	781,639	476,365	108,021,907	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	59	0	0	192.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	1,119	0	0	194.01
194.02	07952	0	150	0	0	194.02
194.03	07953	0	0	0	0	194.03
194.04	07954	0	0	0	0	194.04
194.05	07955	0	0	0	0	194.05
194.06	07956	0	0	0	0	194.06
194.07	07957	0	0	0	0	194.07
200.00						200.00
201.00						201.00
202.00		1,123,904	192,612	665,936	668,125	202.00
203.00		0.217440	0.246003	1.397953	0.006185	203.00
204.00		85,190	34,335	56,531	88,018	204.00
205.00		0.016482	0.043852	0.118672	0.000815	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141348

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/20/2016 1:26 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					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	3,576,141		3,576,141	0	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,317,639		1,317,639	0	0	50.00
53.00	05300 ANESTHESIOLOGY	215,207		215,207	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,138,239		2,138,239	0	0	54.00
60.00	06000 LABORATORY	1,586,451		1,586,451	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	260,971	0	260,971	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,238,986	0	1,238,986	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	339,229	0	339,229	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	63,007	0	63,007	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	103,446		103,446	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	305,447		305,447	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	165,266		165,266	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,292,177		1,292,177	0	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	417,680		417,680	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	3,103,513		3,103,513	0	0	88.00
91.00	09100 EMERGENCY	2,564,348		2,564,348	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	239,639		239,639	0	0	92.00
200.00	Subtotal (see instructions)	18,927,386	0	18,927,386	0	0	200.00
201.00	Less Observation Beds	239,639		239,639		0	201.00
202.00	Total (see instructions)	18,687,747	0	18,687,747	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141348

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/20/2016 1:26 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	10,046,975		10,046,975		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,217,838	7,958,372	9,176,210	0.143593	50.00
53.00	05300	ANESTHESIOLOGY	45,629	230,879	276,508	0.778303	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,438,465	29,175,348	31,613,813	0.067636	54.00
60.00	06000	LABORATORY	4,657,513	18,355,440	23,012,953	0.068937	60.00
65.00	06500	RESPIRATORY THERAPY	1,214,923	472,002	1,686,925	0.154702	65.00
66.00	06600	PHYSICAL THERAPY	3,418,166	3,389,772	6,807,938	0.181991	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,590,574	154,421	1,744,995	0.194401	67.00
68.00	06800	SPEECH PATHOLOGY	112,688	40,999	153,687	0.409970	68.00
69.00	06900	ELECTROCARDIOLOGY	152,621	1,989,150	2,141,771	0.048299	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,644,244	857,619	2,501,863	0.122088	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	293,222	322,769	615,991	0.268293	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,993,474	2,171,188	4,164,662	0.310272	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	163,600	163,600	2.553056	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	2,662,659	2,662,659		88.00
91.00	09100	EMERGENCY	258,351	10,129,787	10,388,138	0.246853	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	66,423	796,796	863,219	0.277611	92.00
200.00		Subtotal (see instructions)	29,151,106	78,870,801	108,021,907		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	29,151,106	78,870,801	108,021,907		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/20/2016 1:26 pm
		Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000 LABORATORY	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC		88.00
91.00	09100 EMERGENCY	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141348

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

Worksheet C  
Part I  
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					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	3,576,141		3,576,141	0	3,576,141	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,317,639		1,317,639	0	1,317,639	50.00
53.00	05300 ANESTHESIOLOGY	215,207		215,207	0	215,207	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,138,239		2,138,239	0	2,138,239	54.00
60.00	06000 LABORATORY	1,586,451		1,586,451	0	1,586,451	60.00
65.00	06500 RESPIRATORY THERAPY	260,971	0	260,971	0	260,971	65.00
66.00	06600 PHYSICAL THERAPY	1,238,986	0	1,238,986	0	1,238,986	66.00
67.00	06700 OCCUPATIONAL THERAPY	339,229	0	339,229	0	339,229	67.00
68.00	06800 SPEECH PATHOLOGY	63,007	0	63,007	0	63,007	68.00
69.00	06900 ELECTROCARDIOLOGY	103,446		103,446	0	103,446	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	305,447		305,447	0	305,447	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	165,266		165,266	0	165,266	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,292,177		1,292,177	0	1,292,177	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	417,680		417,680	0	417,680	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	3,103,513		3,103,513	0	3,103,513	88.00
91.00	09100 EMERGENCY	2,564,348		2,564,348	0	2,564,348	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	239,639		239,639		239,639	92.00
200.00	Subtotal (see instructions)	18,927,386	0	18,927,386	0	18,927,386	200.00
201.00	Less Observation Beds	239,639		239,639		239,639	201.00
202.00	Total (see instructions)	18,687,747	0	18,687,747	0	18,687,747	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141348

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/20/2016 1:26 pm

		Title XIX			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	10,046,975		10,046,975		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,217,838	7,958,372	9,176,210	0.143593	50.00
53.00	05300	ANESTHESIOLOGY	45,629	230,879	276,508	0.778303	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,438,465	29,175,348	31,613,813	0.067636	54.00
60.00	06000	LABORATORY	4,657,513	18,355,440	23,012,953	0.068937	60.00
65.00	06500	RESPIRATORY THERAPY	1,214,923	472,002	1,686,925	0.154702	65.00
66.00	06600	PHYSICAL THERAPY	3,418,166	3,389,772	6,807,938	0.181991	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,590,574	154,421	1,744,995	0.194401	67.00
68.00	06800	SPEECH PATHOLOGY	112,688	40,999	153,687	0.409970	68.00
69.00	06900	ELECTROCARDIOLOGY	152,621	1,989,150	2,141,771	0.048299	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,644,244	857,619	2,501,863	0.122088	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	293,222	322,769	615,991	0.268293	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,993,474	2,171,188	4,164,662	0.310272	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	163,600	163,600	2.553056	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	2,662,659	2,662,659	1.165569	88.00
91.00	09100	EMERGENCY	258,351	10,129,787	10,388,138	0.246853	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	66,423	796,796	863,219	0.277611	92.00
200.00		Subtotal (see instructions)	29,151,106	78,870,801	108,021,907		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	29,151,106	78,870,801	108,021,907		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/20/2016 1:26 pm
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.143593	50.00
53.00	05300 ANESTHESIOLOGY	0.778303	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.067636	54.00
60.00	06000 LABORATORY	0.068937	60.00
65.00	06500 RESPIRATORY THERAPY	0.154702	65.00
66.00	06600 PHYSICAL THERAPY	0.181991	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.194401	67.00
68.00	06800 SPEECH PATHOLOGY	0.409970	68.00
69.00	06900 ELECTROCARDIOLOGY	0.048299	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.122088	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.268293	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.310272	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2.553056	76.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	1.165569	88.00
91.00	09100 EMERGENCY	0.246853	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.277611	92.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

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

Provider CCN: 141348

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

Worksheet C Part II Date/Time Prepared: 11/20/2016 1:26 pm

Cost Center Description		Title XIX			Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,317,639	241,160	1,076,479	0	0	50.00
53.00	05300	ANESTHESIOLOGY	215,207	19,677	195,530	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,138,239	203,313	1,934,926	0	0	54.00
60.00	06000	LABORATORY	1,586,451	135,270	1,451,181	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	260,971	25,121	235,850	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,238,986	145,978	1,093,008	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	339,229	24,345	314,884	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	63,007	1,349	61,658	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	103,446	29,674	73,772	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	305,447	14,717	290,730	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	165,266	7,709	157,557	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,292,177	70,979	1,221,198	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	417,680	36,354	381,326	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	3,103,513	238,708	2,864,805	0	0	88.00
91.00	09100	EMERGENCY	2,564,348	145,653	2,418,695	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	239,639	30,769	208,870	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	15,351,245	1,370,776	13,980,469	0	0	200.00
201.00		Less Observation Beds	239,639	30,769	208,870	0	0	201.00
202.00		Total (line 200 minus line 201)	15,111,606	1,340,007	13,771,599	0	0	202.00

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

Provider CCN: 141348

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

Worksheet C  
Part II  
Date/Time Prepared:  
11/20/2016 1:26 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1,317,639	9,176,210	0.143593	50.00
53.00	05300 ANESTHESIOLOGY	215,207	276,508	0.778303	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,138,239	31,613,813	0.067636	54.00
60.00	06000 LABORATORY	1,586,451	23,012,953	0.068937	60.00
65.00	06500 RESPIRATORY THERAPY	260,971	1,686,925	0.154702	65.00
66.00	06600 PHYSICAL THERAPY	1,238,986	6,807,938	0.181991	66.00
67.00	06700 OCCUPATIONAL THERAPY	339,229	1,744,995	0.194401	67.00
68.00	06800 SPEECH PATHOLOGY	63,007	153,687	0.409970	68.00
69.00	06900 ELECTROCARDIOLOGY	103,446	2,141,771	0.048299	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	305,447	2,501,863	0.122088	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	165,266	615,991	0.268293	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,292,177	4,164,662	0.310272	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	417,680	163,600	2.553056	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	3,103,513	2,662,659	1.165569	88.00
91.00	09100 EMERGENCY	2,564,348	10,388,138	0.246853	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	239,639	863,219	0.277611	92.00
200.00	Subtotal (sum of lines 50 thru 199)	15,351,245	97,974,932		200.00
201.00	Less Observation Beds	239,639	0		201.00
202.00	Total (line 200 minus line 201)	15,111,606	97,974,932		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 141348		Period: From 07/01/2015 To 06/30/2016		Worksheet D Part II Date/Time Prepared: 11/20/2016 1:26 pm	
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	241,160	9,176,210	0.026281	432,703	11,372	50.00
53.00	05300	ANESTHESIOLOGY	19,677	276,508	0.071162	14,063	1,001	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	203,313	31,613,813	0.006431	1,125,439	7,238	54.00
60.00	06000	LABORATORY	135,270	23,012,953	0.005878	2,086,788	12,266	60.00
65.00	06500	RESPIRATORY THERAPY	25,121	1,686,925	0.014892	484,227	7,211	65.00
66.00	06600	PHYSICAL THERAPY	145,978	6,807,938	0.021442	511,899	10,976	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,345	1,744,995	0.013951	107,179	1,495	67.00
68.00	06800	SPEECH PATHOLOGY	1,349	153,687	0.008778	39,826	350	68.00
69.00	06900	ELECTROCARDIOLOGY	29,674	2,141,771	0.013855	80,855	1,120	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,717	2,501,863	0.005882	644,964	3,794	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,709	615,991	0.012515	219,825	2,751	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,979	4,164,662	0.017043	667,995	11,385	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	36,354	163,600	0.222213	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	238,708	2,662,659	0.089650	0	0	88.00
91.00	09100	EMERGENCY	145,653	10,388,138	0.014021	5,036	71	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	30,769	863,219	0.035644	32,155	1,146	92.00
200.00		Total (lines 50-199)	1,370,776	97,974,932		6,452,954	72,176	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/20/2016 1:26 pm
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Cost Center Description	Title XVIII				Hospital	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	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	0	50.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/20/2016 1:26 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	9,176,210	0.000000	0.000000	432,703	50.00
53.00	05300 ANESTHESIOLOGY	0	276,508	0.000000	0.000000	14,063	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	31,613,813	0.000000	0.000000	1,125,439	54.00
60.00	06000 LABORATORY	0	23,012,953	0.000000	0.000000	2,086,788	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,686,925	0.000000	0.000000	484,227	65.00
66.00	06600 PHYSICAL THERAPY	0	6,807,938	0.000000	0.000000	511,899	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,744,995	0.000000	0.000000	107,179	67.00
68.00	06800 SPEECH PATHOLOGY	0	153,687	0.000000	0.000000	39,826	68.00
69.00	06900 ELECTROCARDIOLOGY	0	2,141,771	0.000000	0.000000	80,855	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,501,863	0.000000	0.000000	644,964	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	615,991	0.000000	0.000000	219,825	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4,164,662	0.000000	0.000000	667,995	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	163,600	0.000000	0.000000	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	2,662,659	0.000000	0.000000	0	88.00
91.00	09100 EMERGENCY	0	10,388,138	0.000000	0.000000	5,036	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	863,219	0.000000	0.000000	32,155	92.00
200.00	Total (lines 50-199)	0	97,974,932			6,452,954	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141348

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/20/2016 1:26 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
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141348

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

Worksheet D  
Part V  
Date/Time Prepared:  
11/20/2016 1:26 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	0.143593	0	2,003,276	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.778303	0	45,333	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.067636	0	9,267,766	0	0	54.00
60.00	06000 LABORATORY	0.068937	0	6,884,937	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.154702	0	170,031	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.181991	0	932,209	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.194401	0	40,476	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.409970	0	13,202	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.048299	0	1,871,043	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.122088	0	211,145	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.268293	0	101,557	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.310272	0	801,148	0	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2.553056	0	163,600	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100 EMERGENCY	0.246853	0	2,742,326	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.277611	0	312,654	0	0	92.00
200.00	Subtotal (see instructions)		0	25,560,703	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	25,560,703	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/20/2016 1:26 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	287,656	0	50.00
53.00	05300 ANESTHESIOLOGY	35,283	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	626,835	0	54.00
60.00	06000 LABORATORY	474,627	0	60.00
65.00	06500 RESPIRATORY THERAPY	26,304	0	65.00
66.00	06600 PHYSICAL THERAPY	169,654	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	7,869	0	67.00
68.00	06800 SPEECH PATHOLOGY	5,412	0	68.00
69.00	06900 ELECTROCARDIOLOGY	90,370	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	25,778	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	27,247	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	248,574	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	417,680	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
91.00	09100 EMERGENCY	676,951	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	86,796	0	92.00
200.00	Subtotal (see instructions)	3,207,036	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	3,207,036	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141348	Period: From 07/01/2015	Worksheet D
		Component CCN: 14Z348	To 06/30/2016	Part V
		Title XVIII	Swing Beds - SNF	Date/Time Prepared: 11/20/2016 1:26 pm
				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	0.143593	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.778303	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.067636	0	0	0	54.00
60.00	06000 LABORATORY	0.068937	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.154702	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.181991	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.194401	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.409970	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.048299	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.122088	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.268293	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.310272	0	0	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2.553056	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
91.00	09100 EMERGENCY	0.246853	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.277611	0	0	0	92.00
200.00	Subtotal (see instructions)		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	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/20/2016 1:26 pm
		Component CCN: 14Z348		
		Title XVIII	Swing Beds - SNF	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	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 141348		Period: From 07/01/2015 To 06/30/2016		Worksheet D Part I Date/Time Prepared: 11/20/2016 1:26 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	459,170	245,301	213,869	2,259	94.67	30.00
200.00	Total (Lines 30-199)	459,170		213,869	2,259		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	92	8,710				
200.00	Total (Lines 30-199)	92	8,710				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Prepared: 11/20/2016 1:26 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	241,160	9,176,210	0.026281	0	0	50.00
53.00	05300 ANESTHESIOLOGY	19,677	276,508	0.071162	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	203,313	31,613,813	0.006431	0	0	54.00
60.00	06000 LABORATORY	135,270	23,012,953	0.005878	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	25,121	1,686,925	0.014892	0	0	65.00
66.00	06600 PHYSICAL THERAPY	145,978	6,807,938	0.021442	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	24,345	1,744,995	0.013951	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	1,349	153,687	0.008778	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	29,674	2,141,771	0.013855	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	14,717	2,501,863	0.005882	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7,709	615,991	0.012515	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	70,979	4,164,662	0.017043	0	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	36,354	163,600	0.222213	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	238,708	2,662,659	0.089650	0	0	88.00
91.00	09100 EMERGENCY	145,653	10,388,138	0.014021	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	30,769	863,219	0.035644	0	0	92.00
200.00	Total (lines 50-199)	1,370,776	97,974,932		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 141348		Period: From 07/01/2015 To 06/30/2016		Worksheet D Part III Date/Time Prepared: 11/20/2016 1:26 pm	
Cost Center Description			Title XIX		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,259	0.00	92	0		30.00
200.00		Total (lines 30-199)	2,259		92	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141348

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/20/2016 1:26 pm

Cost Center Description		Title XIX			Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
200.00		Total (Lines 50-199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141348

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/20/2016 1:26 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)	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	9,176,210	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	276,508	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,613,813	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	23,012,953	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,686,925	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,807,938	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,744,995	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	153,687	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,141,771	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,501,863	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	615,991	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,164,662	0.000000	0.000000	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	163,600	0.000000	0.000000	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	2,662,659	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	10,388,138	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	863,219	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	97,974,932			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141348

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/20/2016 1:26 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)		
		11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0		50.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/20/2016 1:26 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)		5,764	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,259	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,934	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,296	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)		1,295	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		461	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)		453	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,358	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)		1,296	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)		1,295	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		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,576,141	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)		1,910,474	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,665,667	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)		1,665,667	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		737.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,001,321	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)		1,001,321	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/20/2016 1:26 pm
Cost Center Description			Title XVIII		Hospital
	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)				857,345 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				1,858,666 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)				955,606 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				954,868 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				1,910,474 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)				325 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				737.35 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				239,639 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141348		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/20/2016 1:26 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	459,170	3,576,141	0.128398	239,639	30,769	90.00
91.00	Nursing School cost	0	3,576,141	0.000000	239,639	0	91.00
92.00	Allied health cost	0	3,576,141	0.000000	239,639	0	92.00
93.00	All other Medical Education	0	3,576,141	0.000000	239,639	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/20/2016 1:26 pm
Cost Center Description		Title XIX	Hospital	PPS
		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)		5,764	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,259	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,934	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,296	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)		1,295	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		460	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)		454	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		92	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		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,576,141	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)		1,910,474	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,665,667	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)		1,665,667	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		737.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		67,836	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)		67,836	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/20/2016 1:26 pm
Cost Center Description			Title XIX	Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				0 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				67,836 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)				8,710 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)				8,710 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				59,126 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)				325 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				737.35 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				239,639 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141348

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

Worksheet D-1

Date/Time Prepared:  
11/20/2016 1:26 pm

Cost Center Description	Cost	Title XIX		Hospital	PPS	
		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	459,170	3,576,141	0.128398	239,639	30,769	90.00
91.00 Nursing School cost	0	3,576,141	0.000000	239,639	0	91.00
92.00 Allied health cost	0	3,576,141	0.000000	239,639	0	92.00
93.00 All other Medical Education	0	3,576,141	0.000000	239,639	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/20/2016 1:26 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		3,683,421		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.143593	432,703	62,133	50.00
53.00	05300 ANESTHESIOLOGY	0.778303	14,063	10,945	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.067636	1,125,439	76,120	54.00
60.00	06000 LABORATORY	0.068937	2,086,788	143,857	60.00
65.00	06500 RESPIRATORY THERAPY	0.154702	484,227	74,911	65.00
66.00	06600 PHYSICAL THERAPY	0.181991	511,899	93,161	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.194401	107,179	20,836	67.00
68.00	06800 SPEECH PATHOLOGY	0.409970	39,826	16,327	68.00
69.00	06900 ELECTROCARDIOLOGY	0.048299	80,855	3,905	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.122088	644,964	78,742	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.268293	219,825	58,978	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.310272	667,995	207,260	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2.553056	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.246853	5,036	1,243	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.277611	32,155	8,927	92.00
200.00	Total (sum of lines 50-94 and 96-98)		6,452,954	857,345	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)		6,452,954		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141348	Period: From 07/01/2015	Worksheet D-3
		Component CCN: 14Z348	To 06/30/2016	Date/Time Prepared: 11/20/2016 1:26 pm
		Title XVIII	Swing Beds - SNF	Cost
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.143593	45,003	6,462 50.00
53.00	05300 ANESTHESIOLOGY	0.778303	1,081	841 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.067636	246,188	16,651 54.00
60.00	06000 LABORATORY	0.068937	950,459	65,522 60.00
65.00	06500 RESPIRATORY THERAPY	0.154702	425,171	65,775 65.00
66.00	06600 PHYSICAL THERAPY	0.181991	2,070,956	376,895 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.194401	1,094,337	212,740 67.00
68.00	06800 SPEECH PATHOLOGY	0.409970	41,473	17,003 68.00
69.00	06900 ELECTROCARDIOLOGY	0.048299	35,667	1,723 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.122088	434,721	53,074 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.268293	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.310272	717,212	222,531 73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2.553056	0	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		0 88.00
91.00	09100 EMERGENCY	0.246853	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.277611	0	0 92.00
200.00	Total (sum of lines 50-94 and 96-98)		6,062,268	1,039,217 200.00
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)		6,062,268	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/20/2016 1:26 pm
		Title XVII	Hospital	Cost
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		3,207,036	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		3,207,036	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		3,239,106	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)		27,220	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,704,501	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)		-492,615	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)		-492,615	30.00
31.00	Primary payer payments		431	31.00
32.00	Subtotal (line 30 minus line 31)		-493,046	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)		618,958	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		402,323	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		473,438	36.00
37.00	Subtotal (see instructions)		-90,723	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)		-90,723	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
41.00	Interim payments		1,351,994	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-1,442,717	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141348

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/20/2016 1:26 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		1,421,505		1,351,994	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,421,505		1,351,994	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		106,195		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		1,442,717	6.02	
7.00	Total Medicare program liability (see instructions)		1,527,700		-90,723	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: 141348  
Component CCN: 14Z348

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/20/2016 1:26 pm

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,908,390		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,908,390		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		74,567		0	6.02
7.00	Total Medicare program liability (see instructions)		2,833,823		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: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/20/2016 1:26 pm
		Title XVIII	Hospital	Cost
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			581 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			1,358 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			192 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			1,934 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			108,021,907 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			148,101 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			3,462 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			3,462 8.00
9.00	Sequestration adjustment amount (see instructions)			69 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			3,393 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)			3,393 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet E-2	
		Component CCN: 14Z348		Date/Time Prepared: 11/20/2016 1:26 pm	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,929,579	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)		1,049,609	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		2,591	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		2,979,188	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		2,979,188	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		2,979,188	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		87,532	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		2,891,656	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT		0		16.55
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		2,891,656	0	19.00
19.01	Sequestration adjustment (see instructions)		57,833	0	19.01
20.00	Interim payments		2,908,390	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		-74,567	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part V Date/Time Prepared: 11/20/2016 1:26 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			1,858,666 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			1,858,666 4.00
5.00	Primary payer payments			1,351 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,875,902 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)			1,875,902 19.00
20.00	Deductibles (exclude professional component)			346,892 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			1,529,010 22.00
23.00	Coinsurance			3,220 23.00
24.00	Subtotal (line 22 minus line 23)			1,525,790 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			50,905 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			33,088 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			31,558 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,558,878 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (see instructions)			1,558,878 30.00
30.01	Sequestration adjustment (see instructions)			31,178 30.01
31.00	Interim payments			1,421,505 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)			106,195 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			99,856 34.00

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

Provider CCN: 141348

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

Worksheet G

Date/Time Prepared:  
11/20/2016 1:26 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	-62,741	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	3,523,499	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-428,621	0	0	0	6.00
7.00	Inventory	468,285	0	0	0	7.00
8.00	Prepaid expenses	277,623	0	0	0	8.00
9.00	Other current assets	252,394	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)	4,030,439	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	39,727	0	0	0	12.00
13.00	Land improvements	356,121	0	0	0	13.00
14.00	Accumulated depreciation	-123,000	0	0	0	14.00
15.00	Buildings	1,848,713	0	0	0	15.00
16.00	Accumulated depreciation	-1,144,056	0	0	0	16.00
17.00	Leasehold improvements	3,479,817	0	0	0	17.00
18.00	Accumulated depreciation	-1,167,437	0	0	0	18.00
19.00	Fixed equipment	2,366,721	0	0	0	19.00
20.00	Accumulated depreciation	-1,088,930	0	0	0	20.00
21.00	Automobiles and trucks	36,543	0	0	0	21.00
22.00	Accumulated depreciation	-15,267	0	0	0	22.00
23.00	Major movable equipment	4,038,043	0	0	0	23.00
24.00	Accumulated depreciation	-3,139,220	0	0	0	24.00
25.00	Minor equipment depreciable	3,040,225	0	0	0	25.00
26.00	Accumulated depreciation	-2,390,286	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)	6,137,714	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,928,673	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,928,673	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	12,096,826	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	905,708	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,008,631	0	0	0	38.00
39.00	Payroll taxes payable	121,371	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	-1,448,258	0	0	0	43.00
44.00	Other current liabilities	41,560	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	629,012	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-10,420	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-10,420	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	618,592	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	11,478,234				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)	11,478,234	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	12,096,826	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141348

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

Worksheet G-1

Date/Time Prepared:  
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		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		11,371,047		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		107,186			2.00
3.00	Total (sum of line 1 and line 2)		11,478,233		0	3.00
4.00	ROUNDING	1		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)		1		0	10.00
11.00	Subtotal (line 3 plus line 10)		11,478,234		0	11.00
12.00		0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,478,234		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	ROUNDING		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00			0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141348

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/20/2016 1:26 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	10,046,975		10,046,975	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	10,046,975		10,046,975	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,046,975		10,046,975	17.00
18.00	Ancillary services	18,779,357	65,281,559	84,060,916	18.00
19.00	Outpatient services	324,774	10,926,583	11,251,357	19.00
20.00	RURAL HEALTH CLINIC	0	2,662,659	2,662,659	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFEE	0	807,615	807,615	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	29,151,106	79,678,416	108,829,522	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,029,200		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		23,029,200		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141348

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

Worksheet G-3

Date/Time Prepared:  
11/20/2016 1:26 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	108,829,522	1.00
2.00	Less contractual allowances and discounts on patients' accounts	85,519,285	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,310,237	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,029,200	4.00
5.00	Net income from service to patients (line 3 minus line 4)	281,037	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	1,711	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	<b>OTHER REIMBURSEMENTS</b>	735,560	24.00
25.00	Total other income (sum of lines 6-24)	737,271	25.00
26.00	Total (line 5 plus line 25)	1,018,308	26.00
27.00	<b>BAD DEBT EXPENSE</b>	911,122	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	911,122	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	107,186	29.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141348 Component CCN: 148514	Period: From 07/01/2015 To 06/30/2016	Worksheet M-1 Date/Time Prepared: 11/20/2016 1:26 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	520,679	0	520,679	0	520,679	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	193,409	0	193,409	0	193,409	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	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	211,325	49,961	261,286	0	261,286	9.00
10.00	Subtotal (sum of lines 1 through 9)	925,413	49,961	975,374	0	975,374	10.00
11.00	Physician Services Under Agreement	0	235,659	235,659	0	235,659	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	235,659	235,659	0	235,659	14.00
15.00	Medical Supplies	0	72,815	72,815	0	72,815	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	68,094	68,094	-68,094	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	140,909	140,909	-68,094	72,815	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	925,413	426,529	1,351,942	-68,094	1,283,848	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	246,544	208,643	455,187	7,281	462,468	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	246,544	208,643	455,187	7,281	462,468	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,171,957	635,172	1,807,129	-60,813	1,746,316	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141348 Component CCN: 148514	Period: From 07/01/2015 To 06/30/2016	Worksheet M-1 Date/Time Prepared: 11/20/2016 1:26 pm Cost
		Rural Health Clinic (RHC) I	

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>			
1.00	Physician	0	520,679
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	193,409
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	0
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	261,286
10.00	Subtotal (sum of lines 1 through 9)	0	975,374
11.00	Physician Services Under Agreement	0	235,659
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	235,659
15.00	Medical Supplies	0	72,815
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	72,815
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,283,848
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
<b>FACILITY OVERHEAD</b>			
29.00	Facility Costs	0	0
30.00	Administrative Costs	-17	462,451
31.00	Total Facility Overhead (sum of lines 29 and 30)	-17	462,451
32.00	Total facility costs (sum of lines 22, 28 and 31)	-17	1,746,299

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141348 Component CCN: 148514	Period: From 07/01/2015 To 06/30/2016	Worksheet M-2 Date/Time Prepared: 11/20/2016 1:26 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	1.91	7,613	4,200	8,022	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	2.04	3,364	2,100	4,284	3.00
4.00	Subtotal (sum of lines 1 through 3)	3.95	10,977		12,306	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.95	10,977		12,306	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)		1,283,848 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)		1,283,848 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)		462,451 14.00
15.00	Parent provider overhead allocated to facility (see instructions)		1,357,214 15.00
16.00	Total overhead (sum of lines 14 and 15)		1,819,665 16.00
17.00	Allowable GME overhead (see instructions)		0 17.00
18.00	Subtotal (see instructions)		1,819,665 18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)		1,819,665 19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		3,103,513 20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141348	Period: From 07/01/2015 To 06/30/2016	Worksheet M-3
		Component CCN: 148514		Date/Time Prepared: 11/20/2016 1:26 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)		3,103,513	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		38,014	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		3,065,499	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		12,306	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		12,306	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		249.11	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)	249.11	249.11	9.00
<b>CALCULATION OF SETTLEMENT</b>				
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,882	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,216,155	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		1,216,155	16.00
16.01	Total program charges (see instructions)(from contractor's records)		922,170	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,519	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		8,597	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.)		916,132	16.04
16.05	Total program cost (see instructions)		924,729	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		62,393	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		170,579	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		924,729	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		27,653	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		952,382	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)		952,382	26.00
26.01	Sequestration adjustment (see instructions)		19,048	26.01
27.00	Interim payments		544,862	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)		388,472	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141348 Component CCN: 148514	Period: From 07/01/2015 To 06/30/2016	Worksheet M-4 Date/Time Prepared: 11/20/2016 1:26 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)	975,374	975,374	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.004950	0.006290	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	4,828	6,135	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,411	2,351	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	7,239	8,486	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,283,848	1,283,848	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	1,819,665	1,819,665	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.005639	0.006610	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	10,261	12,028	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	17,500	20,514	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	172	255	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	101.74	80.45	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	135	173	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	13,735	13,918	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)		38,014	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)		27,653	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141348 Component CCN: 148514	Period: From 07/01/2015 To 06/30/2016	Worksheet M-5 Date/Time Prepared: 11/20/2016 1:26 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		544,862	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)		544,862	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		388,472	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		933,334	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00