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: 140019	Period: From 09/01/2015 To 08/31/2016	Worksheet S Parts I-III Date/Time Prepared: 1/27/2017 11:59 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 1/27/2017 Time: 11:59 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 SHELBY MEMORIAL HOSPITAL (140019) for the cost reporting period beginning 09/01/2015 and ending 08/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	1,225	10,248	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-4,366	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		7,517		0	10.00
200.00	Total	0	-3,141	17,765	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 1/25/2017 2:46 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 200 SOUTH CEDAR	PO Box:			1.00
2.00	City: SHELBYBILLE	State: IL	Zip Code: 62565-1899	County: SHELBY	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	SHELBY MEMORIAL HOSPITAL	140019	99914	1	07/01/1966	N	P	N	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	SHELBY MEMORIAL HOSPITAL SWING BED	14U019	99914		04/13/1993	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	SHELBY MEMORIAL HOSPITAL HHA	147622	99914		08/03/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	SHELBY MEMORIAL HOSPITAL RHC	143446	99914		06/05/1998	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)	09/01/2015	08/31/2016	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	225	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 1/25/2017 2:46 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1		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.	09/01/2015	08/31/2016	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)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	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

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 1/25/2017 2:46 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
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
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	129,588	0	0	118.01

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		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.	N		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140019	Period: From 09/01/2015 To 08/31/2016	Worksheet S-2 Part I Date/Time Prepared: 1/25/2017 2:46 pm

							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
						Beginning	Ending	
						1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
							1.00	
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: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 1/25/2017 2:46 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	12/15/2016	Y	12/15/2016	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 1/25/2017 2:46 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	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATTY		RACHELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544		PRACHELL@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 140019	Period: From 09/01/2015 To 08/31/2016	Worksheet S-2 Part II Date/Time Prepared: 1/25/2017 2:46 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 1/25/2017 2:46 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	30	10,980	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		30	10,980	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		30	10,980	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		30				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: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 1/25/2017 2:46 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)	663	225	1,405			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	264	0	264			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	21			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	927	225	1,690			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)	927	225	1,690	0.00	129.38	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	4,064	0	4,064	0.00	6.97	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,797	2,660	7,789	0.00	11.33	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	147.68	27.00
28.00	Observation Bed Days		61	430			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			3			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: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 1/25/2017 2:46 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
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	223	93	505	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	223	93	505	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 1/25/2017 2:46 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	7,004,318	0	7,004,318	308,367.76	22.71	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		681,602	0	681,602	8,723.75	78.13	5.00
6.00	Non-physician-Part B		220,504	0	220,504	14,935.80	14.76	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		700,011	20,197	720,208	22,755.58	31.65	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		334,404	0	334,404	5,845.00	57.21	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		296,944	0	296,944	3,316.00	89.55	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		1,497,124	0	1,497,124			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		140,928	0	140,928			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		78,347	0	78,347			23.00
24.00	Wage-related costs (RHC/FQHC)		92,235	0	92,235			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	63,959	0	63,959	2,160.00	29.61	26.00
27.00	Administrative & General	5.00	937,500	0	937,500	45,446.37	20.63	27.00
28.00	Administrative & General under contract (see inst.)		128,876	0	128,876	541.25	238.11	28.00
29.00	Maintenance & Repairs	6.00	264,547	0	264,547	10,751.50	24.61	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	46,991	0	46,991	4,237.40	11.09	31.00
32.00	Housekeeping	9.00	187,501	-20,197	167,304	15,203.73	11.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	212,429	-163,424	49,005	4,715.45	10.39	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	163,424	163,424	13,296.60	12.29	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	314,192	0	314,192	11,201.55	28.05	38.00
39.00	Central Services and Supply	14.00	122,412	0	122,412	7,335.80	16.69	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 1/25/2017 2:46 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	222,885	0	222,885	14,865.68	14.99	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-3 Part III Date/Time Prepared: 1/25/2017 2:46 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		6,231,088	0	6,231,088	285,249.46	21.84	1.00
2.00	Excluded area salaries (see instructions)		700,011	20,197	720,208	22,755.58	31.65	2.00
3.00	Subtotal salaries (line 1 minus line 2)		5,531,077	-20,197	5,510,880	262,493.88	20.99	3.00
4.00	Subtotal other wages & related costs (see inst.)		631,348	0	631,348	9,161.00	68.92	4.00
5.00	Subtotal wage-related costs (see inst.)		1,497,124	0	1,497,124	0.00	27.17	5.00
6.00	Total (sum of lines 3 thru 5)		7,659,549	-20,197	7,639,352	271,654.88	28.12	6.00
7.00	Total overhead cost (see instructions)		2,501,292	-20,197	2,481,095	129,755.33	19.12	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-3 Part IV Date/Time Prepared: 1/25/2017 2:46 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	209,462	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	996,223	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	5,328	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)	18,007	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	92,886	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	478,524	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	8,204	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,808,634	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-3 Part V Date/Time Prepared: 1/25/2017 2:46 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	334,404	0	1.00
2.00	Hospital	334,404	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 140019 | Component CCN: 147622 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-4 | Date/Time Prepared: 1/25/2017 2:46 pm

Home Health Agency I | PPS

					1.00		
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	333	0	29	362	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	141.00	5.00	46.00	192.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	1.00	0.00	1.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			1.69	0.00	1.69	5.00
6.00	Direct Nursing Service			3.33	0.00	3.33	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.43	0.00	0.43	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.23	0.00	0.23	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.01	0.00	0.01	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.28	0.00	0.28	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,048	481	31	21	1,581	21.00
22.00	Skilled Nursing Visit Charges	173,560	79,709	5,159	3,495	261,923	22.00
23.00	Physical Therapy Visits	761	39	9	17	826	23.00
24.00	Physical Therapy Visit Charges	137,477	7,018	1,631	3,081	149,207	24.00
25.00	Occupational Therapy Visits	321	26	7	3	357	25.00
26.00	Occupational Therapy Visit Charges	64,955	5,567	1,475	642	72,639	26.00
27.00	Speech Pathology Visits	13	0	0	0	13	27.00
28.00	Speech Pathology Visit Charges	2,618	0	0	0	2,618	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	301	15	1	3	320	31.00
32.00	Home Health Aide Visit Charges	25,951	1,304	87	261	27,603	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,444	561	48	44	3,097	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	404,561	93,598	8,352	7,479	513,990	35.00
36.00	Total Number of Episodes (standard/non outlier)	152		16	3	171	36.00
37.00	Total Number of Outlier Episodes		14		0	14	37.00
38.00	Total Non-Routine Medical Supply Charges	9,623	7,154	153	334	17,264	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-7 | Date/Time Prepared: 1/25/2017 2:46 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	04/13/1993	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	7	7	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	0	6	6	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	0	0	0	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	8	8	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	8	8	30.00
31.00		HD2	0	3	3	31.00
32.00		HD1	0	8	8	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	8	8	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	33	33	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	14	14	48.00
49.00		CC2	0	7	7	49.00
50.00		CC1	0	6	6	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	38	38	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	116	116	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-7 | Date/Time Prepared: 1/25/2017 2:46 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	2	2	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	264	264	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99914	99914	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	0			207.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 140019 Component CCN: 143446 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-8 Date/Time Prepared: 1/25/2017 2:46 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	200 SOUTH CEDAR STREET	1.00
	City	State	ZIP Code
	1.00	2.00	3.00
2.00	City, State, ZIP Code, County	SHELBYVILLE IL	62565 2.00
			1.00
3.00	FQHCs 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 FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0 10.00

		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	Clinic			08:00	17:00	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			14.00

		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		SHELBY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	19:00	08:00	19:00	08:00	19:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 140019 Component CCN: 143446	Period: From 09/01/2015 To 08/31/2016	Worksheet S-8 Date/Time Prepared: 1/25/2017 2:46 pm
		Rural Health Clinic (RHC) I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-10 | Date/Time Prepared: 1/25/2017 2:46 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.447967	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	767,935	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	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	0	5.00
6.00	Medicaid charges	4,724,688	6.00
7.00	Medicaid cost (line 1 times line 6)	2,116,504	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)	1,348,569	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,348,569	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	204,022	16,953	220,975	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	91,395	7,594	98,989	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	91,395	7,594	98,989	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)	745,296	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	95,922	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	649,374	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	290,898	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	389,887	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,738,456	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A | Date/Time Prepared: 1/25/2017 2:46 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,356,533	1,356,533	-251,091	1,105,442	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	697,035	697,035	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	63,959	1,754,459	1,818,418	90,877	1,909,295	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	937,500	1,798,249	2,735,749	-275,090	2,460,659	5.00
6.00	00600	MAINTENANCE & REPAIRS	264,547	104,258	368,805	0	368,805	6.00
7.00	00700	OPERATION OF PLANT	0	282,443	282,443	-51,984	230,459	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,991	21,338	68,329	0	68,329	8.00
9.00	00900	HOUSEKEEPING	187,501	12,164	199,665	-20,197	179,468	9.00
10.00	01000	DIETARY	212,429	240,451	452,880	-348,406	104,474	10.00
11.00	01100	CAFETERIA	0	0	0	348,406	348,406	11.00
13.00	01300	NURSING ADMINISTRATION	314,192	124,872	439,064	0	439,064	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	122,412	12,830	135,242	0	135,242	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	222,885	21,919	244,804	0	244,804	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	116,797	116,797	0	116,797	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	670,534	286,675	957,209	0	957,209	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	143,428	113,465	256,893	-54,505	202,388	50.00
53.00	05300	ANESTHESIOLOGY	0	96	96	0	96	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	432,421	377,146	809,567	0	809,567	54.00
60.00	06000	LABORATORY	414,814	630,235	1,045,049	-16,404	1,028,645	60.00
65.00	06500	RESPIRATORY THERAPY	204,992	55,924	260,916	349	261,265	65.00
66.00	06600	PHYSICAL THERAPY	400,154	21,217	421,371	-654	420,717	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	42,681	42,681	0	42,681	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	1,032,123	1,032,123	4,230	1,036,353	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	32,998	1,900	34,898	0	34,898	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	902,455	54,753	957,208	-4,054	953,154	88.00
90.00	09000	CLINIC	163,945	14,915	178,860	-5,002	173,858	90.00
91.00	09100	EMERGENCY	448,192	847,194	1,295,386	-4,240	1,291,146	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	117,958	94,861	212,819	-5,627	207,192	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	359,376	51,633	411,009	-4,978	406,031	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		208,222	208,222	-208,222	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,663,683	9,679,353	16,343,036	-109,557	16,233,479	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7	7	0	7	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	340,635	3,457	344,092	88,301	432,393	192.00
194.00	07950	FARM EXPENSES	0	0	0	21,256	21,256	194.00
200.00		TOTAL (SUM OF LINES 118-199)	7,004,318	9,682,817	16,687,135	0	16,687,135	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A | Date/Time Prepared: 1/25/2017 2:46 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-208,222	897,220		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	697,035		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-208,147	1,701,148		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-468,099	1,992,560		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	368,805		6.00
7.00	00700	OPERATION OF PLANT	0	230,459		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	68,329		8.00
9.00	00900	HOUSEKEEPING	0	179,468		9.00
10.00	01000	DIETARY	0	104,474		10.00
11.00	01100	CAFETERIA	-77,586	270,820		11.00
13.00	01300	NURSING ADMINISTRATION	0	439,064		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	135,242		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,632	239,172		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-116,797	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-48,035	909,174		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	202,388		50.00
53.00	05300	ANESTHESIOLOGY	0	96		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	809,567		54.00
60.00	06000	LABORATORY	0	1,028,645		60.00
65.00	06500	RESPIRATORY THERAPY	-12,429	248,836		65.00
66.00	06600	PHYSICAL THERAPY	0	420,717		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-1,506	41,175		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,036,353		73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	-22,688	12,210		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-42	953,112		88.00
90.00	09000	CLINIC	-2,863	170,995		90.00
91.00	09100	EMERGENCY	-530,162	760,984		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	207,192		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	-23,972	382,059		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,726,180	14,507,299		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	432,393		192.00
194.00	07950	FARM EXPENSES	0	21,256		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-1,726,180	14,960,955		200.00

RECLASSIFICATIONS | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A-6 | Date/Time Prepared: 1/25/2017 2:46 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - MEDICAL CENTER RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	20,197	0	1.00
	0		20,197	0	
	B - FIRE INSURANCE RECLASS				
1.00	OTHER CAP REL COSTS	3.00	0	34,145	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,401	2.00
	0		0	35,546	
	C - TELEPHONE EXPENSE RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,317	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
	0		0	9,317	
	D - WORKER'S COMPENSATION INS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	90,877	1.00
	0		0	90,877	
	E - RENTAL EXPENSE RECLASS				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	165,247	1.00
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
	0		0	165,247	
	F - MEDICAL CENTER UTILITLES RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	51,984	1.00
	0		0	51,984	
	G - PHYSICIAN BUILDING DEPR RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	14,719	1.00
2.00		0.00	0	0	2.00
	0		0	14,719	
	H - DEPRECIATION EXPENSE RECLASS				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	491,121	1.00
	0		0	491,121	
	I - PROPERTY INSURANCE RECLASS				
1.00	OTHER CAP REL COSTS	3.00	0	43,575	1.00
	0		0	43,575	
	J - CAFETERIA EXPENSE RECLASS				
1.00	CAFETERIA	11.00	163,424	184,982	1.00
	0		163,424	184,982	
	K - REAL ESTATE TAX RECLASS				
1.00	OTHER CAP REL COSTS	3.00	0	9,474	1.00
2.00	FARM EXPENSES	194.00	0	21,256	2.00
	0		0	30,730	
	L - ONCOLOGY PHARMACY COSTS RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,002	1.00
	0		0	5,002	
	M - INTEREST EXPENSE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	208,222	1.00
	0		0	208,222	
	O - PENSION AUDIT COSTS RECLASS				
1.00		0.00	0	0	1.00
	0		0	0	
	Q - RHC PHYSICIAN READING EKGS				
1.00	RESPIRATORY THERAPY	65.00	349	0	1.00
	0		349	0	
500.00	Grand Total: Increases		183,970	1,331,322	500.00

RECLASSIFICATIONS | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A-6 | Date/Time Prepared: 1/25/2017 2:46 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MEDICAL CENTER RECLASS						
1.00	HOUSEKEEPING	9.00	20,197	0	0		1.00
	0		20,197	0			
	B - FIRE INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	35,546	5		1.00
2.00		0.00	0	0	0		2.00
	0		0	35,546			
	C - TELEPHONE EXPENSE RECLASS						
1.00		0.00	0	0	0		1.00
2.00	PHYSICAL THERAPY	66.00	0	654	0		2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	772	0		3.00
4.00	RURAL HEALTH CLINIC	88.00	0	3,705	0		4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	10	0		5.00
6.00	HOME HEALTH AGENCY	101.00	0	4,176	0		6.00
	0		0	9,317			
	D - WORKER'S COMPENSATION INS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	90,877	0		1.00
	0		0	90,877			
	E - RENTAL EXPENSE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	83,679	10		1.00
4.00	OPERATING ROOM	50.00	0	54,505	0		4.00
5.00	LABORATORY	60.00	0	16,404	0		5.00
6.00	EMERGENCY	91.00	0	4,240	0		6.00
7.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	5,617	0		7.00
8.00	HOME HEALTH AGENCY	101.00	0	802	0		8.00
	0		0	165,247			
	F - MEDICAL CENTER UTILITLES RECLASS						
1.00	OPERATION OF PLANT	7.00	0	51,984	0		1.00
	0		0	51,984			
	G - PHYSICIAN BUILDING DEPR RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	13,270	9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,449	9		2.00
	0		0	14,719			
	H - DEPRECIATION EXPENSE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	491,121	9		1.00
	0		0	491,121			
	I - PROPERTY INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	43,575	5		1.00
	0		0	43,575			
	J - CAFETERIA EXPENSE RECLASS						
1.00	DIETARY	10.00	163,424	184,982	0		1.00
	0		163,424	184,982			
	K - REAL ESTATE TAX RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	30,730	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	30,730			
	L - ONCOLOGY PHARMACY COSTS RECLASS						
1.00	CLINIC	90.00	0	5,002	0		1.00
	0		0	5,002			
	M - INTEREST EXPENSE RECLASS						
1.00	INTEREST EXPENSE	113.00	0	208,222	11		1.00
	0		0	208,222			
	O - PENSION AUDIT COSTS RECLASS						
1.00		0.00	0	0	0		1.00
	0		0	0			
	Q - RHC PHYSICIAN READING EKGS						
1.00	RURAL HEALTH CLINIC	88.00	349	0	0		1.00
	0		349	0			
500.00	Grand Total: Decreases		183,970	1,331,322			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 1/25/2017 2:46 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	991,652	0	0	0	0	1.00
2.00	Land Improvements	280,987	0	0	0	0	2.00
3.00	Buildings and Fixtures	15,214,332	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	4,833,910	17,357	0	17,357	0	5.00
6.00	Movable Equipment	10,419,541	133,124	0	133,124	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,740,422	150,481	0	150,481	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	31,740,422	150,481	0	150,481	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	991,652	0	1.00
2.00	Land Improvements	280,987	0	2.00
3.00	Buildings and Fixtures	15,214,332	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,851,267	0	5.00
6.00	Movable Equipment	10,552,665	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,890,903	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	31,890,903	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 1/25/2017 2:46 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,285,129	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,285,129	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	71,404	1,356,533		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	71,404	1,356,533		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A-7 Part III | Date/Time Prepared: 1/25/2017 2:46 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	16,486,971	0	16,486,971	0.516980	40,265	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,403,932	0	15,403,932	0.483020	37,620	2.00
3.00	Total (sum of lines 1-2)	31,890,903	0	31,890,903	1.000000	77,885	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	4,813	0	45,078	780,738	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,496	0	42,116	489,672	165,247	2.00
3.00	Total (sum of lines 1-2)	9,309	0	87,194	1,270,410	165,247	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	40,265	4,813	71,404	897,220	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	37,620	4,496	0	697,035	2.00
3.00	Total (sum of lines 1-2)	0	77,885	9,309	71,404	1,594,255	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A-8 | Date/Time Prepared: 1/25/2017 2:46 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-208,222	CAP REL COSTS-BLDG & FIXT	1.00	11	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)	B	-2,634	ADMINISTRATIVE & GENERAL	5.00	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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-593,489			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-77,586	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	B	-1,506	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,632	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-116,797	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	SELF INSURANCE EXPENSE	A	-207,959	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	ADVERTISING	A	-39,307	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A-8 | Date/Time Prepared: 1/25/2017 2:46 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	MISCELLANEOUS INCOME	B	-2,909	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	NURSING SERVICES SOLD - HOSPITAL	B	-23,972	HOME HEALTH AGENCY	101.00	0	33.03
33.05	PROMOTIONAL ITEMS	A	-42	RURAL HEALTH CLINIC	88.00	0	33.05
33.06	PROMOTIONAL ITEMS	A	-5,103	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	SWITCHBOARD SALARY EXPENSE	A	-736	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	SWITCHBOARD BENEFIT EXPENSE	A	-188	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	PATIENT TELEPHONES	A	-3,705	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	LOBBYING DUES	A	-9,151	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.14	FRA TAX	A	-375,157	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	WELLNESS FOR LIFE REVENUE	B	-22,688	CARDIAC REHABILITATION	76.97	0	33.15
33.16	FOUNDATION AND FUNDRAISING	A	-28,486	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	MISC EXP	A	-911	ADMINISTRATIVE & GENERAL	5.00	0	33.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,726,180				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 1/25/2017 2:46 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	65.00	RESPIRATORY THERAPY	12,429	12,429	0	0	0	1.00
2.00	90.00	CLINIC	2,863	2,863	0	0	0	2.00
3.00	91.00	EMERGENCY	784,920	487,976	296,944	159,800	3,316	3.00
4.00	30.00	ADULTS & PEDIATRICS	48,035	48,035	0	0	0	4.00
5.00	0.00		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			848,247	551,303	296,944		3,316	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	65.00	RESPIRATORY THERAPY	0	0	0	0	0	1.00
2.00	90.00	CLINIC	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	254,758	12,738	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	0.00		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			254,758	12,738	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	65.00	RESPIRATORY THERAPY	0	0	0	12,429		1.00
2.00	90.00	CLINIC	0	0	0	2,863		2.00
3.00	91.00	EMERGENCY	0	254,758	42,186	530,162		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	48,035		4.00
5.00	0.00		0	0	0	0		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	254,758	42,186	593,489		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B Part I | Date/Time Prepared: 1/25/2017 2:46 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	897,220	897,220				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	697,035		697,035			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,701,148	0	0	1,701,148		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,992,560	108,706	84,452	229,631	2,415,349	5.00
6.00	00600	MAINTENANCE & REPAIRS	368,805	21,853	16,978	64,850	472,486	6.00
7.00	00700	OPERATION OF PLANT	230,459	21,025	16,334	0	267,818	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	68,329	18,368	14,269	11,519	112,485	8.00
9.00	00900	HOUSEKEEPING	179,468	8,727	6,780	41,012	235,987	9.00
10.00	01000	DIETARY	104,474	27,801	21,598	12,013	165,886	10.00
11.00	01100	CAFETERIA	270,820	9,751	7,575	40,061	328,207	11.00
13.00	01300	NURSING ADMINISTRATION	439,064	8,385	6,515	77,020	530,984	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	135,242	47,680	37,042	30,008	249,972	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	239,172	21,427	16,646	54,637	331,882	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	909,174	131,266	101,980	164,372	1,306,792	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	202,388	75,920	58,981	35,159	372,448	50.00
53.00	05300	ANESTHESIOLOGY	96	0	0	0	96	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	809,567	64,341	49,986	106,002	1,029,896	54.00
60.00	06000	LABORATORY	1,028,645	25,437	19,761	101,686	1,175,529	60.00
65.00	06500	RESPIRATORY THERAPY	248,836	17,941	13,938	50,336	331,051	65.00
66.00	06600	PHYSICAL THERAPY	420,717	46,985	36,502	98,092	602,296	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	41,175	0	0	0	41,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,036,353	9,629	7,480	0	1,053,462	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	12,210	17,405	13,521	8,089	51,225	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	953,112	58,698	45,602	221,139	1,278,551	88.00
90.00	09000	CLINIC	170,995	94,312	73,269	40,189	378,765	90.00
91.00	09100	EMERGENCY	760,984	24,425	18,975	109,868	914,252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	207,192	21,744	16,892	28,916	274,744	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	382,059	15,394	11,959	88,096	497,508	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,507,299	897,220	697,035	1,612,695	14,418,846	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7	0	0	0	7	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	432,393	0	0	88,453	520,846	192.00
194.00	07950	FARM EXPENSES	21,256	0	0	0	21,256	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,960,955	897,220	697,035	1,701,148	14,960,955	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B Part I | Date/Time Prepared: 1/25/2017 2:46 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,415,349					5.00
6.00	00600	MAINTENANCE & REPAIRS	90,965	563,451				6.00
7.00	00700	OPERATION OF PLANT	51,562	15,452	334,832			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,656	13,499	8,248	155,888		8.00
9.00	00900	HOUSEKEEPING	45,433	6,414	3,919	0	291,753	9.00
10.00	01000	DIETARY	31,937	20,432	12,484	0	11,288	10.00
11.00	01100	CAFETERIA	63,188	7,166	4,379	0	3,959	11.00
13.00	01300	NURSING ADMINISTRATION	102,228	6,163	3,766	0	3,405	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	48,126	35,042	21,411	2,100	19,360	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	63,896	15,747	9,622	0	8,700	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	251,596	96,473	58,944	0	53,298	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	71,706	55,797	34,092	6,554	30,826	50.00
53.00	05300	ANESTHESIOLOGY	18	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	198,281	47,287	28,893	103,152	26,125	54.00
60.00	06000	LABORATORY	226,319	18,695	11,423	0	10,328	60.00
65.00	06500	RESPIRATORY THERAPY	63,736	13,186	8,057	1,221	7,285	65.00
66.00	06600	PHYSICAL THERAPY	115,957	34,532	21,099	41,257	19,078	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,927	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	202,818	7,077	4,324	0	3,910	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	9,862	12,791	7,816	0	7,067	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	246,153	43,140	26,359	1,301	23,834	88.00
90.00	09000	CLINIC	72,922	69,314	42,351	303	38,294	90.00
91.00	09100	EMERGENCY	176,016	17,951	10,968	0	9,917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	52,895	15,980	9,764	0	8,829	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	95,783	11,313	6,913	0	6,250	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,310,980	563,451	334,832	155,888	291,753	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	100,276	0	0	0	0	192.00
194.00	07950	FARM EXPENSES	4,092	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,415,349	563,451	334,832	155,888	291,753	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B Part I | Date/Time Prepared: 1/25/2017 2:46 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	242,027					10.00
11.00	01100	CAFETERIA	0	406,899				11.00
13.00	01300	NURSING ADMINISTRATION	0	21,444	667,990			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,043	60,801	450,855		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,458	0	1,566	459,871	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	242,027	64,201	277,955	18,541	134,825	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,326	44,706	29,019	12,277	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	60	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,902	0	8,653	122,622	54.00
60.00	06000	LABORATORY	0	38,278	0	274,769	49,034	60.00
65.00	06500	RESPIRATORY THERAPY	0	18,730	81,090	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	28,805	0	6,349	24,517	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	52,860	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	17,516	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	3,143	13,609	746	7,374	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	45,292	0	4,137	79,802	88.00
90.00	09000	CLINIC	0	14,815	64,141	3,473	0	90.00
91.00	09100	EMERGENCY	0	29,030	125,688	21,707	29,420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	14,872	0	2,600	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	27,861	0	8,859	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	242,027	391,200	667,990	450,855	459,871	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,699	0	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	242,027	406,899	667,990	450,855	459,871	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B Part I | Date/Time Prepared: 1/25/2017 2:46 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,504,652	0	2,504,652		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	667,751	0	667,751		50.00
53.00	05300	ANESTHESIOLOGY	0	174	0	174		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,596,811	0	1,596,811		54.00
60.00	06000	LABORATORY	0	1,804,375	0	1,804,375		60.00
65.00	06500	RESPIRATORY THERAPY	0	524,356	0	524,356		65.00
66.00	06600	PHYSICAL THERAPY	0	893,890	0	893,890		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	101,962	0	101,962		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,289,107	0	1,289,107		73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	113,633	0	113,633		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,748,569	0	1,748,569		88.00
90.00	09000	CLINIC	0	684,378	0	684,378		90.00
91.00	09100	EMERGENCY	0	1,334,949	0	1,334,949		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	379,684	0	379,684		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	654,487	0	654,487		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	14,298,778	0	14,298,778		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8	0	8		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	636,821	0	636,821		192.00
194.00	07950	FARM EXPENSES	0	25,348	0	25,348		194.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	14,960,955	0	14,960,955		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B Part II | Date/Time Prepared: 1/25/2017 2:46 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	108,706	84,452	193,158	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	21,853	16,978	38,831	0	6.00
7.00	00700	OPERATION OF PLANT	0	21,025	16,334	37,359	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,368	14,269	32,637	0	8.00
9.00	00900	HOUSEKEEPING	0	8,727	6,780	15,507	0	9.00
10.00	01000	DIETARY	0	27,801	21,598	49,399	0	10.00
11.00	01100	CAFETERIA	0	9,751	7,575	17,326	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,385	6,515	14,900	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	47,680	37,042	84,722	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,427	16,646	38,073	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	131,266	101,980	233,246	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	75,920	58,981	134,901	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	64,341	49,986	114,327	0	54.00
60.00	06000	LABORATORY	0	25,437	19,761	45,198	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	17,941	13,938	31,879	0	65.00
66.00	06600	PHYSICAL THERAPY	0	46,985	36,502	83,487	0	66.00
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	9,629	7,480	17,109	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	17,405	13,521	30,926	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	58,698	45,602	104,300	0	88.00
90.00	09000	CLINIC	0	94,312	73,269	167,581	0	90.00
91.00	09100	EMERGENCY	0	24,425	18,975	43,400	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	21,744	16,892	38,636	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	15,394	11,959	27,353	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	897,220	697,035	1,594,255	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FARM EXPENSES	21,256	0	0	21,256	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	21,256	897,220	697,035	1,615,511	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B Part II | Date/Time Prepared: 1/25/2017 2:46 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	193,158					5.00
6.00	00600	MAINTENANCE & REPAIRS	7,274	46,105				6.00
7.00	00700	OPERATION OF PLANT	4,123	1,264	42,746			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,732	1,105	1,053	36,527		8.00
9.00	00900	HOUSEKEEPING	3,633	525	500	0	20,165	9.00
10.00	01000	DIETARY	2,554	1,672	1,594	0	780	10.00
11.00	01100	CAFETERIA	5,053	586	559	0	274	11.00
13.00	01300	NURSING ADMINISTRATION	8,175	504	481	0	235	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,849	2,867	2,733	492	1,338	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,110	1,289	1,228	0	601	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,126	7,892	7,525	0	3,685	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,734	4,566	4,352	1,536	2,131	50.00
53.00	05300	ANESTHESIOLOGY	1	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,856	3,869	3,689	24,170	1,806	54.00
60.00	06000	LABORATORY	18,098	1,530	1,458	0	714	60.00
65.00	06500	RESPIRATORY THERAPY	5,097	1,079	1,029	286	503	65.00
66.00	06600	PHYSICAL THERAPY	9,273	2,826	2,694	9,667	1,319	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	634	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	16,219	579	552	0	270	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	789	1,047	998	0	488	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	19,685	3,530	3,365	305	1,647	88.00
90.00	09000	CLINIC	5,831	5,672	5,407	71	2,647	90.00
91.00	09100	EMERGENCY	14,076	1,469	1,400	0	685	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	4,230	1,308	1,247	0	610	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	7,660	926	882	0	432	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	184,812	46,105	42,746	36,527	20,165	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,019	0	0	0	0	192.00
194.00	07950	FARM EXPENSES	327	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	193,158	46,105	42,746	36,527	20,165	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B Part II | Date/Time Prepared: 1/25/2017 2:46 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	55,999					10.00
11.00	01100	CAFETERIA	0	23,798				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,254	25,549			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	821	2,325	99,147		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,664	0	344	48,309	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	55,999	3,756	10,632	4,077	14,163	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	604	1,710	6,382	1,290	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,866	0	1,903	12,881	54.00
60.00	06000	LABORATORY	0	2,239	0	60,424	5,151	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,095	3,101	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,685	0	1,396	2,575	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,624	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	3,852	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	184	521	164	775	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,649	0	910	8,383	88.00
90.00	09000	CLINIC	0	866	2,453	764	0	90.00
91.00	09100	EMERGENCY	0	1,698	4,807	4,774	3,091	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	870	0	572	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	1,629	0	1,948	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,999	22,880	25,549	99,147	48,309	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	918	0	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	55,999	23,798	25,549	99,147	48,309	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B Part II | Date/Time Prepared: 1/25/2017 2:46 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		361,101	0	361,101		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		163,206	0	163,206		50.00
53.00	05300	ANESTHESIOLOGY		14	0	14		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		180,367	0	180,367		54.00
60.00	06000	LABORATORY		134,812	0	134,812		60.00
65.00	06500	RESPIRATORY THERAPY		44,069	0	44,069		65.00
66.00	06600	PHYSICAL THERAPY		114,922	0	114,922		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		12,258	0	12,258		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		38,581	0	38,581		73.00
76.00	03950	OTHER ANCILLARY COSTS		0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION		35,892	0	35,892		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		144,774	0	144,774		88.00
90.00	09000	CLINIC		191,292	0	191,292		90.00
91.00	09100	EMERGENCY		75,400	0	75,400		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		47,473	0	47,473		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD		0	0	0		97.00
101.00	10100	HOME HEALTH AGENCY		40,830	0	40,830		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,584,991	0	1,584,991		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		8,937	0	8,937		192.00
194.00	07950	FARM EXPENSES		21,583	0	21,583		194.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	1,615,511	0	1,615,511		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B-1 | Date/Time Prepared: 1/25/2017 2:46 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	73,614					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		73,614				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	6,939,623			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,919	8,919	936,764	-2,415,349	12,545,606	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,793	1,793	264,547	0	472,486	6.00
7.00	00700	OPERATION OF PLANT	1,725	1,725	0	0	267,818	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,507	1,507	46,991	0	112,485	8.00
9.00	00900	HOUSEKEEPING	716	716	167,304	0	235,987	9.00
10.00	01000	DIETARY	2,281	2,281	49,005	0	165,886	10.00
11.00	01100	CAFETERIA	800	800	163,424	0	328,207	11.00
13.00	01300	NURSING ADMINISTRATION	688	688	314,192	0	530,984	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,912	3,912	122,412	0	249,972	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,758	1,758	222,885	0	331,882	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,770	10,770	670,534	0	1,306,792	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,229	6,229	143,428	0	372,448	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	96	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,279	5,279	432,421	0	1,029,896	54.00
60.00	06000	LABORATORY	2,087	2,087	414,814	0	1,175,529	60.00
65.00	06500	RESPIRATORY THERAPY	1,472	1,472	205,341	0	331,051	65.00
66.00	06600	PHYSICAL THERAPY	3,855	3,855	400,154	0	602,296	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	41,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	790	790	0	0	1,053,462	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,428	1,428	32,998	0	51,225	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,816	4,816	902,106	0	1,278,551	88.00
90.00	09000	CLINIC	7,738	7,738	163,945	0	378,765	90.00
91.00	09100	EMERGENCY	2,004	2,004	448,192	0	914,252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,784	1,784	117,958	0	274,744	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	1,263	1,263	359,376	0	497,508	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	73,614	73,614	6,578,791	-2,415,349	12,003,497	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	7	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	360,832	0	520,846	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	21,256	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	897,220	697,035	1,701,148		2,415,349	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.188171	9.468783	0.245136		0.192525	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		193,158	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.015396	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B-1 | Date/Time Prepared: 1/25/2017 2:46 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	62,902					6.00
7.00	00700	OPERATION OF PLANT	1,725	61,177				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,507	1,507	19,527			8.00
9.00	00900	HOUSEKEEPING	716	716	0	58,954		9.00
10.00	01000	DIETARY	2,281	2,281	0	2,281	9,063	10.00
11.00	01100	CAFETERIA	800	800	0	800	0	11.00
13.00	01300	NURSING ADMINISTRATION	688	688	0	688	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,912	3,912	263	3,912	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,758	1,758	0	1,758	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,770	10,770	0	10,770	9,063	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,229	6,229	821	6,229	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,279	5,279	12,921	5,279	0	54.00
60.00	06000	LABORATORY	2,087	2,087	0	2,087	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,472	1,472	153	1,472	0	65.00
66.00	06600	PHYSICAL THERAPY	3,855	3,855	5,168	3,855	0	66.00
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	790	790	0	790	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,428	1,428	0	1,428	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,816	4,816	163	4,816	0	88.00
90.00	09000	CLINIC	7,738	7,738	38	7,738	0	90.00
91.00	09100	EMERGENCY	2,004	2,004	0	2,004	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,784	1,784	0	1,784	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	1,263	1,263	0	1,263	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	62,902	61,177	19,527	58,954	9,063	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	563,451	334,832	155,888	291,753	242,027	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.957601	5.473168	7.983203	4.948825	26.704954	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	46,105	42,746	36,527	20,165	55,999	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.732966	0.698727	1.870589	0.342046	6.178859	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B-1 | Date/Time Prepared: 1/25/2017 2:46 pm

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	13.00	14.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	212,557					11.00
13.00	01300	NURSING ADMINISTRATION	11,202	80,597				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,336	7,336	721,063			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,866	0	2,504	12,286		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,537	33,537	29,653	3,602	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,394	5,394	46,411	328	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	96	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,665	0	13,839	3,276	0	54.00
60.00	06000	LABORATORY	19,996	0	439,444	1,310	0	60.00
65.00	06500	RESPIRATORY THERAPY	9,784	9,784	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	15,047	0	10,154	655	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	84,540	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	28,013	0	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,642	1,642	1,193	197	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	23,660	0	6,617	2,132	0	88.00
90.00	09000	CLINIC	7,739	7,739	5,555	0	0	90.00
91.00	09100	EMERGENCY	15,165	15,165	34,717	786	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	7,769	0	4,159	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	14,554	0	14,168	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	204,356	80,597	721,063	12,286	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,201	0	0	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	406,899	667,990	450,855	459,871	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.914305	8.288026	0.625264	37.430490	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	23,798	25,549	99,147	48,309	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.111961	0.316997	0.137501	3.932036	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet C Part I Date/Time Prepared: 1/25/2017 2:46 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,504,652		2,504,652	0	2,504,652	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	667,751		667,751	0	667,751	50.00
53.00	05300	ANESTHESIOLOGY	174		174	0	174	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,596,811		1,596,811	0	1,596,811	54.00
60.00	06000	LABORATORY	1,804,375		1,804,375	0	1,804,375	60.00
65.00	06500	RESPIRATORY THERAPY	524,356	0	524,356	0	524,356	65.00
66.00	06600	PHYSICAL THERAPY	893,890	0	893,890	0	893,890	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	101,962		101,962	0	101,962	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,289,107		1,289,107	0	1,289,107	73.00
76.00	03950	OTHER ANCILLARY COSTS	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	113,633		113,633	0	113,633	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,748,569		1,748,569	0	1,748,569	88.00
90.00	09000	CLINIC	684,378		684,378	0	684,378	90.00
91.00	09100	EMERGENCY	1,334,949		1,334,949	42,186	1,377,135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	586,920		586,920		586,920	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	379,684		379,684	0	379,684	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	654,487		654,487		654,487	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	14,885,698	0	14,885,698	42,186	14,927,884	200.00
201.00		Less Observation Beds	586,920		586,920		586,920	201.00
202.00		Total (see instructions)	14,298,778	0	14,298,778	42,186	14,340,964	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet C Part I Date/Time Prepared: 1/25/2017 2:46 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,319,732		2,319,732			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,173,150	1,173,150	0.569195	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	327,611	327,611	0.000531	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	476,834	9,572,483	10,049,317	0.158897	0.000000	54.00
60.00	06000	LABORATORY	879,691	6,876,403	7,756,094	0.232640	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	154,840	1,694,869	1,849,709	0.283480	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	146,764	1,281,780	1,428,544	0.625735	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	209,977	165,514	375,491	0.271543	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	283,985	945,279	1,229,264	1.048682	0.000000	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	139,640	139,640	0.813757	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	675,379	675,379			88.00
90.00	09000	CLINIC	3,100	406,026	409,126	1.672781	0.000000	90.00
91.00	09100	EMERGENCY	104,835	2,170,136	2,274,971	0.586798	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	140,724	712,258	852,982	0.688080	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	355,518	355,518	1.067974	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	702,755	702,755			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,720,482	27,198,801	31,919,283			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,720,482	27,198,801	31,919,283			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet C Part I Date/Time Prepared: 1/25/2017 2:46 pm

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		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.569195
53.00	05300	ANESTHESIOLOGY	0.000531
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158897
60.00	06000	LABORATORY	0.232640
65.00	06500	RESPIRATORY THERAPY	0.283480
66.00	06600	PHYSICAL THERAPY	0.625735
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.271543
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1.048682
76.00	03950	OTHER ANCILLARY COSTS	0.000000
76.97	07697	CARDIAC REHABILITATION	0.813757
		OUTPATIENT SERVICE COST CENTERS	
88.00	08800	RURAL HEALTH CLINIC	
90.00	09000	CLINIC	1.672781
91.00	09100	EMERGENCY	0.605342
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.688080
		OTHER REIMBURSABLE COST CENTERS	
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.067974
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000
101.00	10100	HOME HEALTH AGENCY	
		SPECIAL PURPOSE COST CENTERS	
113.00	11300	INTEREST EXPENSE	
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part I | Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	361,101	0	361,101	1,835	196.79	30.00
200.00	Total (lines 30-199)	361,101		361,101	1,835		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	663	130,472	30.00
200.00	Total (lines 30-199)	663	130,472	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part II Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	163,206	1,173,150	0.139118	0	0	50.00
53.00	05300	ANESTHESIOLOGY	14	327,611	0.000043	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	180,367	10,049,317	0.017948	439,015	7,879	54.00
60.00	06000	LABORATORY	134,812	7,756,094	0.017381	683,555	11,881	60.00
65.00	06500	RESPIRATORY THERAPY	44,069	1,849,709	0.023825	125,955	3,001	65.00
66.00	06600	PHYSICAL THERAPY	114,922	1,428,544	0.080447	74,238	5,972	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,258	375,491	0.032645	155,842	5,087	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	38,581	1,229,264	0.031385	158,615	4,978	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	35,892	139,640	0.257032	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	144,774	675,379	0.214360	0	0	88.00
90.00	09000	CLINIC	191,292	409,126	0.467563	0	0	90.00
91.00	09100	EMERGENCY	75,400	2,274,971	0.033143	79,487	2,634	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	84,617	852,982	0.099201	108,009	10,715	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	47,473	355,518	0.133532	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50-199)	1,267,677	28,896,796		1,824,716	52,147	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part III Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	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	1,835	0.00	663	0		30.00
200.00		Total (lines 30-199)	1,835		663	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part IV | Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
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
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	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part IV Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,173,150	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	327,611	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,049,317	0.000000	0.000000	439,015	54.00
60.00	06000	LABORATORY	0	7,756,094	0.000000	0.000000	683,555	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,849,709	0.000000	0.000000	125,955	65.00
66.00	06600	PHYSICAL THERAPY	0	1,428,544	0.000000	0.000000	74,238	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	375,491	0.000000	0.000000	155,842	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,229,264	0.000000	0.000000	158,615	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	139,640	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	675,379	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	409,126	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	2,274,971	0.000000	0.000000	79,487	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	852,982	0.000000	0.000000	108,009	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	355,518	0.000000	0.000000	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	28,896,796			1,824,716	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part IV Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	648,976	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,860,956	0		54.00
60.00	06000	LABORATORY	0	1,299,952	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	748,606	0		65.00
66.00	06600	PHYSICAL THERAPY	0	269,588	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	92,177	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	895,502	0		73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	80,815	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	437	0		90.00
91.00	09100	EMERGENCY	0	691,172	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	381,553	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
200.00		Total (lines 50-199)	0	8,969,734	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part V Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.569195	648,976	0	0	369,394	50.00
53.00	05300	ANESTHESIOLOGY	0.000531	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158897	3,860,956	0	0	613,494	54.00
60.00	06000	LABORATORY	0.232640	1,299,952	0	0	302,421	60.00
65.00	06500	RESPIRATORY THERAPY	0.283480	748,606	0	0	212,215	65.00
66.00	06600	PHYSICAL THERAPY	0.625735	269,588	0	0	168,691	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.271543	92,177	0	0	25,030	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.048682	895,502	0	759	939,097	73.00
76.00	03950	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.813757	80,815	0	0	65,764	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.672781	437	0	0	731	90.00
91.00	09100	EMERGENCY	0.586798	691,172	0	0	405,578	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.688080	381,553	0	0	262,539	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.067974	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Subtotal (see instructions)		8,969,734	0	759	3,364,954	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		8,969,734	0	759	3,364,954	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part V Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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
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	796		73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00		Subtotal (see instructions)	0	796		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	796		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,120	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,835	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)	1,405	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	88	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)	176	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	7	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)	14	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	663	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)	88	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)	176	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,504,652	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,504,652	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,504,652	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,364.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	904,949	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)	904,949	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	642,030	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,546,979	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)	130,472	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	52,147	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	182,619	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,364,360	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)	430	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,364.93	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	586,920	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	361,101	2,504,652	0.144172	586,920	84,617	90.00
91.00	Nursing School cost	0	2,504,652	0.000000	586,920	0	91.00
92.00	Allied health cost	0	2,504,652	0.000000	586,920	0	92.00
93.00	All other Medical Education	0	2,504,652	0.000000	586,920	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-3 | Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,159,590		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.569195	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000531	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158897	439,015	69,758	54.00
60.00	06000	LABORATORY	0.232640	683,555	159,022	60.00
65.00	06500	RESPIRATORY THERAPY	0.283480	125,955	35,706	65.00
66.00	06600	PHYSICAL THERAPY	0.625735	74,238	46,453	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.271543	155,842	42,318	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.048682	158,615	166,337	73.00
76.00	03950	OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.813757	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.672781	0	0	90.00
91.00	09100	EMERGENCY	0.605342	79,487	48,117	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.688080	108,009	74,319	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.067974	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		1,824,716	642,030	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)		1,824,716		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140019 | Component CCN: 14U019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-3 | Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.569195	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000531	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158897	37,819	6,009	54.00
60.00	06000	LABORATORY	0.232640	89,199	20,751	60.00
65.00	06500	RESPIRATORY THERAPY	0.283480	28,885	8,188	65.00
66.00	06600	PHYSICAL THERAPY	0.625735	72,526	45,382	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.271543	44,911	12,195	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.048682	49,035	51,422	73.00
76.00	03950	OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.813757	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.672781	0	0	90.00
91.00	09100	EMERGENCY	0.586798	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.688080	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.067974	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		322,375	143,947	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)		322,375		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140019	Period: From 09/01/2015 To 08/31/2016	Worksheet E Part A Date/Time Prepared: 1/25/2017 2:46 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	89,231	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	981,541	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	0	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	28.05	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	6.77	30.00
31.00	Percentage of Medicaid patient days (see instructions)	15.98	31.00
32.00	Sum of lines 30 and 31	22.75	32.00
33.00	Allowable disproportionate share percentage (see instructions)	7.98	33.00
34.00	Disproportionate share adjustment (see instructions)	21,362	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140019	Period: From 09/01/2015 To 08/31/2016	Worksheet E Part A Date/Time Prepared: 1/25/2017 2:46 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000007209	0.000006557	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	55,132	42,005	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	4,531	38,562	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	43,093		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	1,135,227		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	1,314,781		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		1,314,781	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		84,630	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		1,399,411	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		1,399,411	61.00
62.00	Deductibles billed to program beneficiaries		193,004	62.00
63.00	Coinsurance billed to program beneficiaries		0	63.00
64.00	Allowable bad debts (see instructions)		29,000	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		18,850	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		29,000	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		1,225,257	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-5,006	70.93
70.94	HRR adjustment amount (see instructions)		-272	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140019	Period: From 09/01/2015 To 08/31/2016	Worksheet E Part A Date/Time Prepared: 1/25/2017 2:46 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2015	24,411	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2016	306,889	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		1,551,279	71.00
71.01	Sequestration adjustment (see instructions)		31,026	71.01
72.00	Interim payments		1,519,028	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		1,225	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	89,231	0	89,231		89,231	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	981,541	0		981,541	981,541	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0798	0.0798	0.0798	0.0798		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	21,362	0	1,780	19,582	21,362	11.00
11.01	Uncompensated care payments	36.00	43,093	0	43,093	0	43,093	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,135,227	0	134,104	1,001,123	1,135,227	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	1,314,781	0	109,187	1,205,594	1,314,781	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	1,314,781	0	109,187	1,205,594	1,314,781	15.00
16.00	Payment for inpatient program capital	50.00	84,630	0	0	84,630	84,630	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	109,187	1,290,224	1,399,411	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	84,630	0	0	84,630	84,630	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	84,630	0	0	84,630	84,630	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.223571	0.237857		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			24,411		24,411	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				306,889	306,889	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	89,231	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	981,541		1,070,772	1,070,772	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0798	0.0798	0.0798		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	21,362	0	21,362	21,362	11.00
11.01	Uncompensated care payments	36.00	43,093	4,531	0	4,531	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,135,227	4,531	1,130,696	1,135,227	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	1,314,781	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	1,314,781	0	1,314,781	1,314,781	15.00
16.00	Payment for inpatient program capital	50.00	84,630	0	84,630	84,630	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	1,399,411	1,399,411	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 1/25/2017 2:46 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	84,630	0	84,630	84,630	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	84,630	0	84,630	84,630	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	24,411	24,411		24,411	28.00
29.00	Low volume adjustment on or after October 1	70.97	306,889		306,889	306,889	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-5,006	0	-5,006	-5,006	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-272	0	-272	-272	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140019	Period: From 09/01/2015 To 08/31/2016	Worksheet E Part B Date/Time Prepared: 1/25/2017 2:46 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	796	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,364,954	2.00
3.00	PPS payments	1,836,276	3.00
4.00	Outlier payment (see instructions)	7,156	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)	796	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	759	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)	759	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis 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)	759	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)	37	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	759	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)	1,843,432	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	404,030	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,440,161	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,440,161	30.00
31.00	Primary payer payments	799	31.00
32.00	Subtotal (line 30 minus line 31)	1,439,362	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	77,415	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	50,320	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	77,415	36.00
37.00	Subtotal (see instructions)	1,489,682	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENT	9,206	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,498,888	40.00
40.01	Sequestration adjustment (see instructions)	29,978	40.01
41.00	Interim payments	1,458,662	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	10,248	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,414,061		1,458,662	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	08/30/2016	104,967		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)		104,967		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)		1,519,028		1,458,662	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		1,225		10,248	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,520,253		1,468,910	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: 140019 | Component CCN: 14U019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		62,107		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	08/30/2016	16,552		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)		16,552		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)		78,659		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		4,366		0	6.02
7.00	Total Medicare program liability (see instructions)		74,293		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: 140019	Period: From 09/01/2015 To 08/31/2016	Worksheet E-1 Part II Date/Time Prepared: 1/25/2017 2:46 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	505	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	663	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,405	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	31,919,283	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	220,975	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 140019 | Component CCN: 14U019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet E-2 | Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	69,458	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	264	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)	69,458	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	69,458	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)	69,458	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,083	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)	63,375	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)	19,129	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	12,434	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	19,129	0	18.00
19.00	Total (see instructions)	75,809	0	19.00
19.01	Sequestration adjustment (see instructions)	1,516	0	19.01
20.00	Interim payments	78,659	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)	-4,366	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet G | Date/Time Prepared: 1/25/2017 2:46 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	415,491	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	5,389,145	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,021,304	0	0	0	6.00
7.00	Inventory	181,368	0	0	0	7.00
8.00	Prepaid expenses	262,165	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	121,519	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,348,384	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	991,652	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	-414,201	0	0	0	14.00
15.00	Buildings	15,495,319	0	0	0	15.00
16.00	Accumulated depreciation	-10,574,085	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	4,851,267	0	0	0	19.00
20.00	Accumulated depreciation	-3,912,376	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,552,665	0	0	0	23.00
24.00	Accumulated depreciation	-9,128,233	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,862,008	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	17,485,008	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	124,215	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	17,609,223	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	28,819,615	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	412,611	0	0	0	37.00
38.00	Salaries, wages, and fees payable	642,517	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	300,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	121,147	0	0	0	43.00
44.00	Other current liabilities	30,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,506,275	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,050,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,050,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,556,275	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	20,263,340				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)	20,263,340	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	28,819,615	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet G-1 | Date/Time Prepared: 1/25/2017 2:46 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		22,134,085		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,870,745				2.00
3.00	Total (sum of line 1 and line 2)		20,263,340		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		20,263,340		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		20,263,340		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140019 | Period: From 09/01/2015 To 08/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 1/25/2017 2:46 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,955,288		1,955,288	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	367,399		367,399	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)	2,322,687		2,322,687	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)	2,322,687		2,322,687	17.00
18.00	Ancillary services	2,160,409	22,408,314	24,568,723	18.00
19.00	Outpatient services	249,230	3,304,940	3,554,170	19.00
20.00	RURAL HEALTH CLINIC	0	675,379	675,379	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		702,755	702,755	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	DME	0	355,518	355,518	27.00
27.01	PRO FEES	0	117,073	117,073	27.01
27.02	DR. VASKO REVENUES	0	610,997	610,997	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,732,326	28,174,976	32,907,302	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,687,135		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)		16,687,135		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140019	Period: From 09/01/2015 To 08/31/2016	Worksheet G-3 Date/Time Prepared: 1/25/2017 2:46 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	32,907,302	1.00
2.00	Less contractual allowances and discounts on patients' accounts	19,661,575	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,245,727	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,687,135	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,441,408	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	56,580	6.00
7.00	Income from investments	1,128,198	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	77,536	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	1,506	17.00
18.00	Revenue from sale of medical records and abstracts	5,632	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	102,047	22.00
23.00	Governmental appropriations	0	23.00
24.00	FARM INCOME	154,711	24.00
24.01	NURSING SERVICES	23,972	24.01
24.02	MISCELLANEOUS INCOME	28,281	24.02
24.03	EHR INCENTIVE PAYMENT	-7,800	24.03
25.00	Total other income (sum of lines 6-24)	1,570,663	25.00
26.00	Total (line 5 plus line 25)	-1,870,745	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,870,745	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140019 | HHA CCN: 147622 | Period: From 09/01/2015 To 08/31/2016 | Worksheet H | Date/Time Prepared: 1/25/2017 2:46 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	150,852	0	25,955	0	24,927	201,734	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	140,294	0	0	0	0	140,294	6.00
7.00	Physical Therapy	37,876	0	0	0	0	37,876	7.00
8.00	Occupational Therapy	8,933	0	0	0	0	8,933	8.00
9.00	Speech Pathology	1,657	0	0	0	0	1,657	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	19,764	0	0	0	0	19,764	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	750	750	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	359,376	0	25,955	0	25,677	411,008	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-4,977	196,757	0	196,757			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	140,294	-23,972	116,322			6.00
7.00	Physical Therapy	0	37,876	0	37,876			7.00
8.00	Occupational Therapy	0	8,933	0	8,933			8.00
9.00	Speech Pathology	0	1,657	0	1,657			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	19,764	0	19,764			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	750	0	750			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-4,977	406,031	-23,972	382,059			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 140019 HHA CCN: 147622

Period: From 09/01/2015 To 08/31/2016

Worksheet H-1 Part I Date/Time Prepared: 1/25/2017 2:46 pm

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	196,757	0	0	0	0	196,757	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	116,322	0	0	0	0	116,322	6.00
7.00	Physical Therapy	37,876	0	0	0	0	37,876	7.00
8.00	Occupational Therapy	8,933	0	0	0	0	8,933	8.00
9.00	Speech Pathology	1,657	0	0	0	0	1,657	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	19,764	0	0	0	0	19,764	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	750	0	0	0	0	750	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	382,059	0	0	0	0	382,059	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	196,757		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	123,514	239,836	6.00
7.00	Physical Therapy	40,217	78,093	7.00
8.00	Occupational Therapy	9,485	18,418	8.00
9.00	Speech Pathology	1,759	3,416	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	20,986	40,750	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	796	1,546	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		382,059	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 140019 | HHA CCN: 147622 | Period: From 09/01/2015 To 08/31/2016 | Worksheet H-1 Part II | Date/Time Prepared: 1/25/2017 2:46 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-196,757	185,302	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	116,322	6.00
7.00	Physical Therapy	0	0	0	0	0	37,876	7.00
8.00	Occupational Therapy	0	0	0	0	0	8,933	8.00
9.00	Speech Pathology	0	0	0	0	0	1,657	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	19,764	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	750	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-196,757	185,302	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		196,757	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		1.061818	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140019 HHA CCN: 147622 | Period: From 09/01/2015 To 08/31/2016 | Worksheet H-2 Part I Date/Time Prepared: 1/25/2017 2:46 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	15,394	11,959	36,979	64,332	12,386	1.00
2.00	Skilled Nursing Care	239,836	0	0	34,391	274,227	52,794	2.00
3.00	Physical Therapy	78,093	0	0	9,285	87,378	16,823	3.00
4.00	Occupational Therapy	18,418	0	0	2,190	20,608	3,968	4.00
5.00	Speech Pathology	3,416	0	0	406	3,822	736	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	40,750	0	0	4,845	45,595	8,778	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	1,546	0	0	0	1,546	298	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	382,059	15,394	11,959	88,096	497,508	95,783	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	11,313	6,913	0	6,250	0	27,861	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	11,313	6,913	0	6,250	0	27,861	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140019 HHA CCN: 147622 | Period: From 09/01/2015 To 08/31/2016 | Worksheet H-2 Part I Date/Time Prepared: 1/25/2017 2:46 pm

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	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	14.00	16.00	19.00	24.00	25.00	
1.00	Administrative and General	0	8,859	0	0	137,914	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	327,021	0	2.00
3.00	Physical Therapy	0	0	0	0	104,201	0	3.00
4.00	Occupational Therapy	0	0	0	0	24,576	0	4.00
5.00	Speech Pathology	0	0	0	0	4,558	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	54,373	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	1,844	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	8,859	0	0	654,487	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs				
		26.00	27.00	28.00				
1.00	Administrative and General	137,914						1.00
2.00	Skilled Nursing Care	327,021	87,309	414,330				2.00
3.00	Physical Therapy	104,201	27,819	132,020				3.00
4.00	Occupational Therapy	24,576	6,561	31,137				4.00
5.00	Speech Pathology	4,558	1,217	5,775				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	54,373	14,516	68,889				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	1,844	492	2,336				19.00
19.50	Telemedicine	0	0	0				19.50
20.00	Total (sum of lines 1-19) (2)	654,487	137,914	654,487				20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.266979					21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140019 HHA CCN: 147622

Period: From 09/01/2015 To 08/31/2016

Worksheet H-2 Part II Date/Time Prepared: 1/25/2017 2:46 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	1,263	1,263	150,852	0	64,332	1,263	1.00
2.00	Skilled Nursing Care	0	0	140,294	0	274,227	0	2.00
3.00	Physical Therapy	0	0	37,876	0	87,378	0	3.00
4.00	Occupational Therapy	0	0	8,933	0	20,608	0	4.00
5.00	Speech Pathology	0	0	1,657	0	3,822	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	19,764	0	45,595	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	1,546	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,263	1,263	359,376		497,508	1,263	20.00
21.00	Total cost to be allocated	15,394	11,959	88,096		95,783	11,313	21.00
22.00	Unit cost multiplier	12.188440	9.468725	0.245136		0.192526	8.957245	22.00

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	1,263	0	1,263	0	14,554	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,263	0	1,263	0	14,554	0	20.00
21.00	Total cost to be allocated	6,913	0	6,250	0	27,861	0	21.00
22.00	Unit cost multiplier	5.473476	0.000000	4.948535	0.000000	1.914319	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140019 HHA CCN: 147622

Period: From 09/01/2015 To 08/31/2016

Worksheet H-2 Part II Date/Time Prepared: 1/25/2017 2:46 pm

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	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)			
		14.00	16.00	19.00			
1.00	Administrative and General	14,168	0	0			1.00
2.00	Skilled Nursing Care	0	0	0			2.00
3.00	Physical Therapy	0	0	0			3.00
4.00	Occupational Therapy	0	0	0			4.00
5.00	Speech Pathology	0	0	0			5.00
6.00	Medical Social Services	0	0	0			6.00
7.00	Home Health Aide	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0			8.00
9.00	Drugs	0	0	0			9.00
10.00	DME	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0			13.00
14.00	Clinic	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0			15.00
16.00	Day Care Program	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0			17.00
18.00	Homemaker Service	0	0	0			18.00
19.00	All Others (specify)	0	0	0			19.00
19.50	Telemedicine	0	0	0			19.50
20.00	Total (sum of lines 1-19)	14,168	0	0			20.00
21.00	Total cost to be allocated	8,859	0	0			21.00
22.00	Unit cost multiplier	0.625282	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140019 | HHA CCN: 147622 | Period: From 09/01/2015 To 08/31/2016 | Worksheet H-3 Part I | Date/Time Prepared: 1/25/2017 2:46 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	414,330		414,330	2,062	200.94	1.00
2.00	Physical Therapy	3.00	132,020	0	132,020	1,191	110.85	2.00
3.00	Occupational Therapy	4.00	31,137	0	31,137	433	71.91	3.00
4.00	Speech Pathology	5.00	5,775	0	5,775	15	385.00	4.00
5.00	Medical Social Services	6.00	0		0	1	0.00	5.00
6.00	Home Health Aide	7.00	68,889		68,889	362	190.30	6.00
7.00	Total (sum of lines 1-6)		652,151	0	652,151	4,064		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	1,581			8.00
9.00	Physical Therapy		99914	0	826			9.00
10.00	Occupational Therapy		99914	0	357			10.00
11.00	Speech Pathology		99914	0	13			11.00
12.00	Medical Social Services		99914	0	0			12.00
13.00	Home Health Aide		99914	0	320			13.00
14.00	Total (sum of lines 8-13)			0	3,097			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,581		0	317,686		1.00
2.00	Physical Therapy	0	826		0	91,562		2.00
3.00	Occupational Therapy	0	357		0	25,672		3.00
4.00	Speech Pathology	0	13		0	5,005		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	320		0	60,896		6.00
7.00	Total (sum of lines 1-6)	0	3,097		0	500,821		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 140019 HHA CCN: 147622 | Period: From 09/01/2015 To 08/31/2016 | Worksheet H-3 Part I Date/Time Prepared: 1/25/2017 2:46 pm

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	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	317,686	1.00
2.00	Physical Therapy	91,562	2.00
3.00	Occupational Therapy	25,672	3.00
4.00	Speech Pathology	5,005	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	60,896	6.00
7.00	Total (sum of lines 1-6)	500,821	7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140019 | HHA CCN: 147622 | Period: From 09/01/2015 To 08/31/2016 | Worksheet H-3 Part II | Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.625735	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.271543	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	1.048682	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 140019 HHA CCN: 147622	Period: From 09/01/2015 To 08/31/2016	Worksheet H-4 Part I-II Date/Time Prepared: 1/25/2017 2:46 pm
	Title XVIII	Home Health Agency I	PPS

		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	407,308	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	35,012	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	6,706	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	6,510	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	11,716	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	4,241	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	471,493	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	471,493	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	471,493	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	471,493	29.00
30.00	OTHER ADJUSTMENT	0	-3,353	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	468,140	31.00
31.01	Sequestration adjustment (see instructions)	0	9,363	31.01
32.00	Interim payments (see instructions)	0	458,777	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 140019 HHA CCN: 147622 | Period: From 09/01/2015 To 08/31/2016 | Worksheet H-5 Date/Time Prepared: 1/25/2017 2:46 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		458,777	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		458,777	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		458,777	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140019	Period: From 09/01/2015 To 08/31/2016	Worksheet L Parts I-III Date/Time Prepared: 1/25/2017 2:46 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	84,630	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	3.85	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	84,630	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 140019 Component CCN: 143446 | Period: From 09/01/2015 To 08/31/2016 | Worksheet M-1 | Date/Time Prepared: 1/25/2017 2:46 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	493,938	0	493,938	-349	493,589	1.00
2.00	Physician Assistant	104,046	0	104,046	0	104,046	2.00
3.00	Nurse Practitioner	83,618	0	83,618	0	83,618	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	78,132	0	78,132	0	78,132	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	759,734	0	759,734	-349	759,385	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	6,617	6,617	0	6,617	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	1,281	1,281	0	1,281	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	7,898	7,898	0	7,898	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	759,734	7,898	767,632	-349	767,283	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
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
	FACILITY OVERHEAD						
29.00	Facility Costs	0	19,198	19,198	0	19,198	29.00
30.00	Administrative Costs	142,721	27,657	170,378	-3,705	166,673	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	142,721	46,855	189,576	-3,705	185,871	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	902,455	54,753	957,208	-4,054	953,154	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 140019 | Component CCN: 143446 | Period: From 09/01/2015 To 08/31/2016 | Worksheet M-1 | Date/Time Prepared: 1/25/2017 2:46 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	493,589		1.00
2.00	Physician Assistant	0	104,046		2.00
3.00	Nurse Practitioner	0	83,618		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	78,132		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	759,385		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	6,617		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	1,281		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	7,898		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	767,283		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	19,198		29.00
30.00	Administrative Costs	-42	166,631		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-42	185,829		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-42	953,112		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140019 Component CCN: 143446 | Period: From 09/01/2015 To 08/31/2016 | Worksheet M-2 Date/Time Prepared: 1/25/2017 2:46 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	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.49	3,656	4,200	6,258		1.00
2.00	Physician Assistant	1.04	2,304	2,100	2,184		2.00
3.00	Nurse Practitioner	0.61	1,829	2,100	1,281		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.14	7,789		9,723	9,723	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)	3.14	7,789			9,723	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					767,283	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)					767,283	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)					185,829	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					795,457	15.00
16.00	Total overhead (sum of lines 14 and 15)					981,286	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					981,286	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					981,286	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,748,569	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 140019 Component CCN: 143446	Period: From 09/01/2015 To 08/31/2016	Worksheet M-3 Date/Time Prepared: 1/25/2017 2:46 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		1,748,569	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		13,004	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,735,565	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		9,723	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)		9,723	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		178.50	7.00

		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions)	178.50	178.50	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,797	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	320,765	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) *		320,765	16.00
16.01	Total program charges (see instructions)(from contractor's records)		160,544	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,872	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,740	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.)		241,976	16.04
16.05	Total program cost (see instructions)		245,716	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		14,555	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		29,198	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		245,716	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,907	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		250,623	22.00
23.00	Allowable bad debts (see instructions)		22,027	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		14,318	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		22,027	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)		264,941	26.00
26.01	Sequestration adjustment (see instructions)		5,299	26.01
27.00	Interim payments		252,125	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)		7,517	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: 140019 | Component CCN: 143446 | Period: From 09/01/2015 To 08/31/2016 | Worksheet M-4 | Date/Time Prepared: 1/25/2017 2:46 pm

Title XVIII | Rural Health Clinic (RHC) I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	759,385	759,385	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.002581	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	1,960	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	3,746	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	5,706	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	767,283	767,283	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	981,286	981,286	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.007437	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	7,298	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	13,004	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	212	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	61.34	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	80	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	4,907	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)		13,004	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)		4,907	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140019 Component CCN: 143446	Period: From 09/01/2015 To 08/31/2016	Worksheet M-5 Date/Time Prepared: 1/25/2017 2:46 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		235,573	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		08/30/2016	16,552	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)		16,552	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		252,125	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		7,517	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		259,642	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00