This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1313	Period: From 10/01/2015 To 09/30/2016	Worksheet S Parts I-III Date/Time Prepared: 2/14/2017 3:53 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/14/2017 Time: 3:53 pm
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 MASON DISTRICT HOSPITAL (14-1313) for the cost reporting period beginning 10/01/2015 and ending 09/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	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	-180,236	-239,985	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	-63,309	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	89		0	9.00
10.00	RURAL HEALTH CLINIC I	0		65,233		0	10.00
10.01	RURAL HEALTH CLINIC II	0		1,501		0	10.01
200.00	Total	0	-243,545	-173,162	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/14/2017 3:52 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 615 NORTH PROMENADE STREET	PO Box:			1.00
2.00	City: HAVANA	State: IL	Zip Code: 62644-0530	County: MASON	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	MASON DISTRICT HOSPITAL	141313	99914	1	07/01/2001	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MASON DISTRICT HOSPITAL	14Z313	99914		07/01/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	MASON DISTRICT HHA	147202	99914		01/09/1982	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	HAVANA MEDICAL ASSOCIATES RHC	143457	99914		02/01/2001	O	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	MASON CITY MEDICAL ASSOCIATES	143462	99914		03/03/2003	O	O	O	15.01
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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2015	09/30/2016	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/14/2017 3:52 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	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.				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)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/14/2017 3:52 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

		1.00	
	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	
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/14/2017 3:52 pm

		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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/14/2017 3:52 pm

		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 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.	Y		108.00

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

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

		1.00	2.00	3.00	
	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:	64,219	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/14/2017 3:52 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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

		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.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1313	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 2/14/2017 3:52 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2016	12/31/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 2/14/2017 3:52 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.	Y			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)	N		N		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)	Y	01/04/2017	Y	01/04/2017	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 2/14/2017 3:52 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.				Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	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.				Y	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.	DAN		LINHART		41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563.888.4404		DAN.LINHART@RSMUS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1313	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Prepared: 2/14/2017 3:52 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.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 2/14/2017 3:52 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	25	9,150	15,268.10	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	15,268.10	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,150	15,268.10	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
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/14/2017 3:52 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)	430	44	659			1.00
2.00	HMO and other (see instructions)	47	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	276	0	306			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	38			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	706	44	1,003			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	706	44	1,003	0.00	164.14	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	4,666	747	17,735	0.00	10.11	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	4,670	4,071	14,372	0.00	33.75	26.00
26.01	RURAL HEALTH CLINIC II	253	530	1,894	0.00	3.99	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	211.99	27.00
28.00	Observation Bed Days		0	163			28.00
29.00	Ambulance Trips	689					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/14/2017 3:52 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	140	15	213	1.00
2.00	HMO and other (see instructions)			31	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	140	15	213	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
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 14-1313
Component CCN: 14-7202
Period: From 10/01/2015 To 09/30/2016
Worksheet S-4
Date/Time Prepared: 2/14/2017 3:52 pm

Home Health Agency I | PPS

					1.00		
0.00	County				MASON		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	1,152	66	594	1,812	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	164.00	9.00	85.00	258.00	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			2.01	0.00	2.01	5.00
6.00	Direct Nursing Service			6.23	0.00	6.23	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.87	0.00	0.87	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.			2			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
20.01				99917			20.01
		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	2,574	203	55	25	2,857	21.00
22.00	Skilled Nursing Visit Charges	654,202	51,765	14,025	6,375	726,367	22.00
23.00	Physical Therapy Visits	953	47	3	3	1,006	23.00
24.00	Physical Therapy Visit Charges	266,793	13,207	843	843	281,686	24.00
25.00	Occupational Therapy Visits	443	22	9	3	477	25.00
26.00	Occupational Therapy Visit Charges	124,806	6,182	2,529	843	134,360	26.00
27.00	Speech Pathology Visits	39	0	3	0	42	27.00
28.00	Speech Pathology Visit Charges	10,927	0	843	0	11,770	28.00
29.00	Medical Social Service Visits	4	2	0	0	6	29.00
30.00	Medical Social Service Visit Charges	1,124	562	0	0	1,686	30.00
31.00	Home Health Aide Visits	203	74	1	0	278	31.00
32.00	Home Health Aide Visit Charges	28,612	10,434	141	0	39,187	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,216	348	71	31	4,666	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)	1,086,464	82,150	18,381	8,061	1,195,056	35.00
36.00	Total Number of Episodes (standard/non outlier)	224		27	3	254	36.00
37.00	Total Number of Outlier Episodes		9		0	9	37.00
38.00	Total Non-Routine Medical Supply Charges	8,354	531	448	324	9,657	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1313 | Component CCN: 14-3457 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-8 | Date/Time Prepared: 2/14/2017 3:52 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			615 PROMENADE BOX 530		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	HAVANA		IL	62644-0530	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	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	RHC/FQHC 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		MASON				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	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1313 Component CCN: 14-3457	Period: From 10/01/2015 To 09/30/2016	Worksheet S-8 Date/Time Prepared: 2/14/2017 3:52 pm
		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-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1313 | Component CCN: 14-3462 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-8 | Date/Time Prepared: 2/14/2017 3:52 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			615 N PROMENADE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	HAVANA		IL	62644	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	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	RHC/FQHC 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		MASON				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	17:00	08:00	17:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1313
Component CCN: 14-3462

Period:
From 10/01/2015
To 09/30/2016

Worksheet S-8

Date/Time Prepared:
2/14/2017 3:52 pm

RHC II

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: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-10 | Date/Time Prepared: 2/14/2017 3:52 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)	0.566739	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,360,868	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,369,661	5.00
6.00	Medicaid charges	4,012,264	6.00
7.00	Medicaid cost (line 1 times line 6)	2,273,906	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)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	18,601	9.00
10.00	Stand-alone CHIP charges	46,746	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	26,493	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	7,892	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	1,154,212	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	7,892	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	30,973	28,051	59,024	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	17,554	15,898	33,452	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)	17,554	15,898	33,452	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,492,367	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	172,806	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,319,561	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	747,847	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	781,299	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	789,191	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/14/2017 3:52 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		0	0	263,160	263,160	1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING		0	0	65,248	65,248	1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG		0	0	528,646	528,646	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,286,260	1,286,260	-597,286	688,974	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,100,770	3,100,770	0	3,100,770	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	867,085	1,070,296	1,937,381	0	1,937,381	5.01
5.02	00591	A&G HOSPITAL ONLY	364,402	206,505	570,907	0	570,907	5.02
6.00	00600	MAINTENANCE & REPAIRS	306,323	221,545	527,868	0	527,868	6.00
7.00	00700	OPERATION OF PLANT	0	226,470	226,470	0	226,470	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	26,577	26,577	0	26,577	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	28,059	16,274	44,333	0	44,333	8.00
9.00	00900	HOUSEKEEPING	224,147	56,708	280,855	0	280,855	9.00
10.00	01000	DIETARY	214,538	197,698	412,236	0	412,236	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	158,290	19,079	177,369	0	177,369	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	59,899	28,238	88,137	0	88,137	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	172,042	69,727	241,769	0	241,769	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	316,716	316,716	0	316,716	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	870,703	173,994	1,044,697	0	1,044,697	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	191,044	41,307	232,351	0	232,351	50.00
53.00	05300	ANESTHESIOLOGY	0	580	580	0	580	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	520,046	270,286	790,332	-61,388	728,944	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	63,117	72,454	135,571	2,277	137,848	54.01
56.00	05600	RADIOISOTOPE	26,821	83,601	110,422	347	110,769	56.00
58.00	05800	MRI	0	88,453	88,453	950	89,403	58.00
60.00	06000	LABORATORY	667,337	612,920	1,280,257	46,056	1,326,313	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	46,976	46,976	0	46,976	62.00
64.00	06400	INTRAVENOUS THERAPY	0	14,089	14,089	0	14,089	64.00
66.00	06600	PHYSICAL THERAPY	463,171	116,841	580,012	0	580,012	66.00
67.00	06700	OCCUPATIONAL THERAPY	161,844	28,048	189,892	0	189,892	67.00
68.00	06800	SPEECH PATHOLOGY	18,834	2,489	21,323	0	21,323	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	343,835	129,300	473,135	11,758	484,893	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	350,414	350,414	0	350,414	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	289,891	347,377	637,268	0	637,268	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	172,533	129,616	302,149	0	302,149	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	5,768	15,420	21,188	0	21,188	76.01
76.02	03950	DIABETIC EDUCATION	77,838	14,438	92,276	0	92,276	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,853,531	601,667	3,455,198	-113,063	3,342,135	88.00
88.01	08801	RURAL HEALTH CLINIC II	293,141	69,544	362,685	0	362,685	88.01
91.00	09100	EMERGENCY	391,250	1,754,927	2,146,177	567,881	2,714,058	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	883,035	95,922	978,957	-567,881	411,076	95.00
101.00	10100	HOME HEALTH AGENCY	530,079	103,853	633,932	0	633,932	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		259,768	259,768	-259,768	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,218,603	12,267,147	23,485,750	-113,063	23,372,687	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	34,029	4,187	38,216	113,063	151,279	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	11,252,632	12,271,334	23,523,966	0	23,523,966	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/14/2017 3:52 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	-17,616	245,544		1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	65,248		1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	-20,897	507,749		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-137,181	551,793		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,245,144	1,855,626		4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	-118,090	1,819,291		5.01
5.02	00591	A&G HOSPITAL ONLY	-200	570,707		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	527,868		6.00
7.00	00700	OPERATION OF PLANT	-253	226,217		7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	26,577		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	44,333		8.00
9.00	00900	HOUSEKEEPING	0	280,855		9.00
10.00	01000	DIETARY	-142,506	269,730		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	177,369		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	88,137		14.00
15.00	01500	PHARMACY	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,796	237,973		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-52,845	263,871		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,044,697		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	232,351		50.00
53.00	05300	ANESTHESIOLOGY	0	580		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-28,379	700,565		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	137,848		54.01
56.00	05600	RADIOISOTOPE	0	110,769		56.00
58.00	05800	MRI	0	89,403		58.00
60.00	06000	LABORATORY	0	1,326,313		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	46,976		62.00
64.00	06400	INTRAVENOUS THERAPY	0	14,089		64.00
66.00	06600	PHYSICAL THERAPY	0	580,012		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	189,892		67.00
68.00	06800	SPEECH PATHOLOGY	0	21,323		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	-39,076	445,817		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	350,414		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	637,268		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	302,149		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	21,188		76.01
76.02	03950	DIABETIC EDUCATION	0	92,276		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-156	3,341,979		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	362,685		88.01
91.00	09100	EMERGENCY	-466,022	2,248,036		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	411,076		95.00
101.00	10100	HOME HEALTH AGENCY	-4,300	629,632		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,276,461	21,096,226		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	151,279		192.00
194.00	07950	HOSPICE	0	0		194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0		194.01
194.02	07952	MEALS ON WHEELS	0	0		194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-2,276,461	21,247,505		200.00

RECLASSIFICATIONS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/14/2017 3:52 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - INTEREST RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	18,804	1.00
2.00	NEW CAP REL COSTS-NEW MED SURG	1.02	0	240,964	2.00
	TOTALS		0	259,768	
	B - EMS SALARY TO ER				
1.00	EMERGENCY	91.00	567,881	0	1.00
	TOTALS		567,881	0	
	C - DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	244,356	1.00
2.00	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	65,248	2.00
3.00	NEW CAP REL COSTS-NEW MED SURG	1.02	0	287,682	3.00
	TOTALS		0	597,286	
	D - RHC PHYSICIAN				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	113,063	0	1.00
	TOTALS		113,063	0	
	E - OP REGISTRATION				
1.00	LABORATORY	60.00	41,430	4,626	1.00
2.00	CARDIOPULMONARY	69.01	10,577	1,181	2.00
3.00	RADIOLOGY-ULTRASOUND	54.01	2,048	229	3.00
4.00	RADIOISOTOPE	56.00	312	35	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	3,215	359	5.00
6.00	MRI	58.00	855	95	6.00
	TOTALS		58,437	6,525	
500.00	Grand Total: Increases		739,381	863,579	500.00

RECLASSIFICATIONS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/14/2017 3:52 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	259,768	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	259,768			
	B - EMS SALARY TO ER						
1.00	AMBULANCE SERVICES	95.00	567,881	0	0		1.00
	TOTALS		567,881	0			
	C - DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	597,286	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
	TOTALS		0	597,286			
	D - RHC PHYSICIAN						
1.00	RURAL HEALTH CLINIC	88.00	113,063	0	0		1.00
	TOTALS		113,063	0			
	E - OP REGISTRATION						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	58,437	6,525	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		58,437	6,525			
500.00	Grand Total: Decreases		739,381	863,579			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 2/14/2017 3:52 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	163,928	0	0	0	0	1.00
2.00	Land Improvements	582,643	20,990	0	20,990	0	2.00
3.00	Buildings and Fixtures	14,674,797	11,128	0	11,128	-1,611,185	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	3,411,374	80,679	0	80,679	0	5.00
6.00	Movable Equipment	8,441,020	194,598	0	194,598	-219,010	6.00
7.00	HIT designated Assets	810,377	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,084,139	307,395	0	307,395	-1,830,195	8.00
9.00	Reconciling Items	-484,051	-1,357,877	0	-1,357,877	-1,830,195	9.00
10.00	Total (line 8 minus line 9)	28,568,190	1,665,272	0	1,665,272	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	163,928	0	1.00
2.00	Land Improvements	603,633	0	2.00
3.00	Buildings and Fixtures	16,297,110	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	3,492,053	0	5.00
6.00	Movable Equipment	8,854,628	0	6.00
7.00	HIT designated Assets	810,377	0	7.00
8.00	Subtotal (sum of lines 1-7)	30,221,729	0	8.00
9.00	Reconciling Items	-11,733	0	9.00
10.00	Total (line 8 minus line 9)	30,233,462	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 2/14/2017 3:52 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	0	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	1,286,260	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,286,260	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,286,260	2.00
3.00	Total (sum of lines 1-2)	0	1,286,260	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part III | Date/Time Prepared: 2/14/2017 3:52 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	20,568,457	0	20,568,457	0.680321	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0.000000	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	9,665,005	0	9,665,005	0.319679	0	2.00
3.00	Total (sum of lines 1-2)	30,233,462	0	30,233,462	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	209,207	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	65,248	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	286,480	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	551,793	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,112,728	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	13,344	0	0	22,993	245,544	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	65,248	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	221,269	0	0	0	507,749	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	551,793	2.00
3.00	Total (sum of lines 1-2)	234,613	0	0	22,993	1,370,334	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/14/2017 3:52 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)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-CLINIC BUILDING (chapter 2)		0	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-NEW MED SURG (chapter 2)		0	NEW CAP REL COSTS-NEW MED SURG	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-527,121			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		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	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	*** Cost Center Deleted ***	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
26.01	Depreciation - NEW CAP REL COSTS-CLINIC BUILDING		0	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-NEW MED SURG		0	NEW CAP REL COSTS-NEW MED SURG	1.02	0	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/14/2017 3:52 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	
28.00	Non-physician Anesthetist		0	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	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-137,181	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MEDICAL RECORD FEES -OTHER OP	B	-3,796	MEDICAL RECORDS & LIBRARY	16.00	0	33.00
33.01	CAFETERIA SALES -OTHER OP	B	-132,106	DIETARY	10.00	0	33.01
33.02	DIETARY CONSULT -OTHER OP	B	-10,400	DIETARY	10.00	0	33.02
33.03	SALE OF NON-PAT SUPP-OTHER OP	B	-2,736	ADMINISTRATIVE AND GENERAL	5.01	0	33.03
33.04	ON-CALL CRNA SERVICES	A	-52,845	NONPHYSICIAN ANESTHETISTS	19.00	0	33.04
33.05	PROF BUILDING RENT -OTHER OP	B	-27,949	CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
33.06	MISCELLANEOUS -OTHER OP	B	-45,063	ADMINISTRATIVE AND GENERAL	5.01	0	33.06
33.07	RENTAL INCOME	B	-7,200	CAP REL COSTS-BLDG & FIXT	1.00	9	33.07
33.08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.08
33.09	COMMUNITY ED FEES -OTHER OP	B	-930	ADMINISTRATIVE AND GENERAL	5.01	0	33.09
33.10			0		0.00	0	33.10
33.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.11
33.12	INTEREST INCOME -NON OPER	B	-5,460	CAP REL COSTS-BLDG & FIXT	1.00	11	33.12
33.13	INTEREST INCOME -NON OPER	B	-19,695	NEW CAP REL COSTS-NEW MED SURG	1.02	11	33.13
33.14	FITNESS REV OTHER	B	-6,356	CARDIOPULMONARY	69.01	0	33.14
33.15			0		0.00	0	33.15
33.16	TELEPHONE OFFSET - OPERATIONS	A	-253	OPERATION OF PLANT	7.00	0	33.16
33.17	TELEPHONE OFFSET - SALARIES	A	-86	ADMINISTRATIVE AND GENERAL	5.01	0	33.17
33.18	TELEPHONE OFFSET - BENEFITS	A	-15	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19	MEDICAR - EXPENSES	A	-15,048	ADMINISTRATIVE AND GENERAL	5.01	0	33.19
33.20	MEDICAR - BENEFITS	A	-2,124	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	LOBBYING DUES	A	-11,781	ADMINISTRATIVE AND GENERAL	5.01	0	33.21
33.22	ADVERTISING	A	-14,936	ADMINISTRATIVE AND GENERAL	5.01	0	33.22
33.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.23
33.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.24
33.25	ADVERTISING	A	-200	A&G HOSPITAL ONLY	5.02	0	33.25
33.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.26
33.27	ADVERTISING	A	-156	RURAL HEALTH CLINIC	88.00	0	33.27
33.28			0		0.00	0	33.28
33.34	TELEVISIONS	A	-1,202	NEW CAP REL COSTS-NEW MED SURG	1.02	9	33.34
33.35	SELF INSURANCE	A	-470,187	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.35
33.36	UNFUNDED POST-EMPLOYMENT BENEFIT	A	-7,133	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.36
33.37	NON-ALLOW DONATION EXP	A	-27,510	ADMINISTRATIVE AND GENERAL	5.01	0	33.37
33.38	BOND AMORTIZTION COST FY14	A	22,993	CAP REL COSTS-BLDG & FIXT	1.00	14	33.38
33.39	HOME HEALTH BLDG RENT	B	-4,300	HOME HEALTH AGENCY	101.00	0	33.39
33.40	IMRF CONTRIBUTION	A	-765,685	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.40
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,276,461				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: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 2/14/2017 3:52 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	91.00	EMERGENCY	1,640,346	466,022	1,174,324	0	0	1.00
2.00	60.00	LABORATORY	48,000	0	48,000	0	0	2.00
3.00	69.01	CARDIOPULMONARY	32,720	32,720	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	28,379	28,379	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			1,749,445	527,121	1,222,324		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.01	CARDIOPULMONARY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	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			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	466,022		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	69.01	CARDIOPULMONARY	0	0	0	32,720		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	28,379		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	0	0	527,121		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/14/2017 3:52 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	245,544	245,544				1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	65,248	0	65,248			1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	507,749	0	0	507,749		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	551,793				551,793	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,855,626	0	0	0	0	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	1,819,291	53,969	3,461	0	49,682	5.01
5.02	00591	A&G HOSPITAL ONLY	570,707	2,831	4,263	4,168	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	527,868	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	226,217	24,865	546	11,114	2,425	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	26,577	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	44,333	7,323	0	4,130	3,070	8.00
9.00	00900	HOUSEKEEPING	280,855	878	0	2,441	0	9.00
10.00	01000	DIETARY	269,730	11,904	0	0	715	10.00
11.00	01100	CAFETERIA	0	5,060	0	2,816	0	11.00
13.00	01300	NURSING ADMINISTRATION	177,369	3,718	0	6,045	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	88,137	6,365	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	237,973	6,009	663	0	110,435	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	263,871	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,044,697	3,619	0	395,821	27,230	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	232,351	29,301	0	0	81,821	50.00
53.00	05300	ANESTHESIOLOGY	580	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	700,565	22,063	0	0	94,922	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	137,848	1,141	0	0	0	54.01
56.00	05600	RADIOISOTOPE	110,769	2,479	0	0	0	56.00
58.00	05800	MRI	89,403	0	0	0	0	58.00
60.00	06000	LABORATORY	1,326,313	12,707	0	0	5,516	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	46,976	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	14,089	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	580,012	4,835	0	0	80,865	66.00
67.00	06700	OCCUPATIONAL THERAPY	189,892	1,014	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	21,323	732	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	445,817	22,842	0	0	15,831	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	350,414	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	637,268	0	0	70,213	1,509	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	302,149	0	2,777	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	21,188	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	92,276	2,704	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,341,979	0	47,885	0	2,253	88.00
88.01	08801	RURAL HEALTH CLINIC II	362,685	0	0	0	1,657	88.01
91.00	09100	EMERGENCY	2,248,036	19,185	0	0	1,210	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	411,076	0	0	0	66,195	95.00
101.00	10100	HOME HEALTH AGENCY	629,632	0	5,653	0	6,457	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,096,226	245,544	65,248	496,748	551,793	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	11,001	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	151,279	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	21,247,505	245,544	65,248	507,749	551,793	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/14/2017 3:52 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE AND GENERAL	Subtotal	A&G HOSPITAL ONLY	
			4.00	4A	5.01	5A.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,855,626					4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	141,090	2,067,493	2,067,493			5.01
5.02	00591	A&G HOSPITAL ONLY	60,159	642,128	69,218	711,346	711,346	5.02
6.00	00600	MAINTENANCE & REPAIRS	50,571	578,439	62,352	640,791	30,762	6.00
7.00	00700	OPERATION OF PLANT	0	265,167	28,583	293,750	14,102	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	26,577	2,865	29,442	1,413	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	4,632	63,488	6,844	70,332	3,376	8.00
9.00	00900	HOUSEKEEPING	37,004	321,178	34,621	355,799	17,081	9.00
10.00	01000	DIETARY	35,418	317,767	34,253	352,020	16,899	10.00
11.00	01100	CAFETERIA	0	7,876	849	8,725	419	11.00
13.00	01300	NURSING ADMINISTRATION	26,132	213,264	22,989	236,253	11,342	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,889	104,391	11,253	115,644	5,552	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,402	383,482	41,337	424,819	20,394	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	263,871	28,444	292,315	14,033	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	143,743	1,615,110	174,099	1,789,209	85,895	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,539	375,012	40,424	415,436	19,944	50.00
53.00	05300	ANESTHESIOLOGY	0	580	63	643	31	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	76,737	894,287	96,399	990,686	47,560	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	10,758	149,747	16,142	165,889	7,964	54.01
56.00	05600	RADIOISOTOPE	4,479	117,727	12,690	130,417	6,261	56.00
58.00	05800	MRI	141	89,544	9,652	99,196	4,762	58.00
60.00	06000	LABORATORY	117,010	1,461,546	157,546	1,619,092	77,728	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	46,976	5,064	52,040	2,498	62.00
64.00	06400	INTRAVENOUS THERAPY	0	14,089	1,519	15,608	749	64.00
66.00	06600	PHYSICAL THERAPY	76,464	742,176	80,002	822,178	39,470	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,719	217,625	23,459	241,084	11,574	67.00
68.00	06800	SPEECH PATHOLOGY	3,109	25,164	2,713	27,877	1,338	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	58,510	543,000	58,532	601,532	28,878	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	350,414	37,773	388,187	18,636	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,858	756,848	81,584	838,432	40,251	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	28,483	333,409	35,939	369,348	17,731	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	952	22,140	2,387	24,527	1,177	76.01
76.02	03950	DIABETIC EDUCATION	12,850	107,830	11,623	119,453	5,735	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	452,420	3,844,537	414,418	4,258,955	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	48,394	412,736	44,490	457,226	0	88.01
91.00	09100	EMERGENCY	158,342	2,426,773	261,592	2,688,365	129,057	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	52,028	529,299	57,055	586,354	28,149	95.00
101.00	10100	HOME HEALTH AGENCY	87,510	729,252	78,609	807,861	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,831,343	21,060,942	2,047,382	21,040,831	710,761	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,001	1,186	12,187	585	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	24,283	175,562	18,925	194,487	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,855,626	21,247,505	2,067,493	21,247,505	711,346	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/14/2017 3:52 pm

		Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			6.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS	671,553					6.00
7.00	00700	OPERATION OF PLANT	55,261	363,113				7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	30,855			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	16,048	12,619	0	102,375		8.00
9.00	00900	HOUSEKEEPING	2,433	1,913	0	0	377,226	9.00
10.00	01000	DIETARY	24,385	19,174	0	0	15,387	10.00
11.00	01100	CAFETERIA	11,087	8,717	0	0	6,996	11.00
13.00	01300	NURSING ADMINISTRATION	9,164	7,205	0	0	5,782	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,039	10,252	0	0	8,228	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,106	9,678	399	0	8,901	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	108,781	85,534	0	37,929	68,642	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	60,021	47,193	0	16,552	37,874	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,193	35,535	0	14,454	28,518	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	2,337	1,837	0	0	1,474	54.01
56.00	05600	RADIOISOTOPE	5,077	3,992	0	0	3,204	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	26,029	20,467	0	86	16,425	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	9,904	7,787	0	3,157	6,250	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,077	1,633	0	0	1,311	67.00
68.00	06800	SPEECH PATHOLOGY	1,500	1,179	0	0	947	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	46,789	36,790	0	2,386	29,525	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,981	14,138	0	0	11,346	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	7,529	0	1,669	0	4,751	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	5,539	4,355	0	0	3,495	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	129,830	0	28,787	823	81,922	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	39	0	88.01
91.00	09100	EMERGENCY	39,299	30,900	0	26,015	24,798	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	807	0	95.00
101.00	10100	HOME HEALTH AGENCY	15,327	0	0	61	9,672	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	668,736	360,898	30,855	102,309	375,448	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,817	2,215	0	0	1,778	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	66	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	671,553	363,113	30,855	102,375	377,226	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/14/2017 3:52 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	427,865					10.00
11.00	01100	CAFETERIA	345,755	381,699				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,859	272,605			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,154	0	158,869		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,554	0	0	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	56,874	50,813	142,901	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	467	10,184	30,430	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,706	0	3,105	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	2,995	0	165	0	54.01
56.00	05600	RADIOISOTOPE	0	1,089	0	11,845	0	56.00
58.00	05800	MRI	0	109	0	612	0	58.00
60.00	06000	LABORATORY	0	39,567	0	59,598	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	9,538	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,861	0	64.00
66.00	06600	PHYSICAL THERAPY	0	18,027	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,610	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	408	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	18,490	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71,145	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,184	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	23,689	9,368	27,951	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	381	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	3,159	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	91,226	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	1,080	69,821	71,323	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	427,865	378,704	272,605	158,869	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	2,995	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	427,865	381,699	272,605	158,869	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/14/2017 3:52 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	490,851					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	306,348				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,257	0	2,453,835	0	2,453,835	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,494	0	655,595	0	655,595	50.00
53.00	05300	ANESTHESIOLOGY	10,831	306,348	317,853	0	317,853	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	77,468	0	1,268,225	0	1,268,225	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	9,838	0	192,499	0	192,499	54.01
56.00	05600	RADIOISOTOPE	8,357	0	170,242	0	170,242	56.00
58.00	05800	MRI	15,171	0	119,850	0	119,850	58.00
60.00	06000	LABORATORY	93,701	0	1,952,693	0	1,952,693	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,000	0	65,076	0	65,076	62.00
64.00	06400	INTRAVENOUS THERAPY	6,512	0	25,730	0	25,730	64.00
66.00	06600	PHYSICAL THERAPY	20,353	0	927,126	0	927,126	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,646	0	270,935	0	270,935	67.00
68.00	06800	SPEECH PATHOLOGY	288	0	33,537	0	33,537	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	24,480	0	788,870	0	788,870	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,983	0	487,951	0	487,951	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,239	0	944,571	0	944,571	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	13,410	0	475,446	0	475,446	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	821	0	26,906	0	26,906	76.01
76.02	03950	DIABETIC EDUCATION	975	0	142,711	0	142,711	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	43,930	0	4,635,473	0	4,635,473	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,586	0	460,851	0	460,851	88.01
91.00	09100	EMERGENCY	35,015	0	3,115,673	0	3,115,673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	26,861	0	642,171	0	642,171	95.00
101.00	10100	HOME HEALTH AGENCY	23,635	0	856,556	0	856,556	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	490,851	306,348	21,030,375	0	21,030,375	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	19,582	0	19,582	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	197,548	0	197,548	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	490,851	306,348	21,247,505	0	21,247,505	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/14/2017 3:52 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	0	53,969	3,461	0	49,682	5.01
5.02	00591	A&G HOSPITAL ONLY	0	2,831	4,263	4,168	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	24,865	546	11,114	2,425	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,323	0	4,130	3,070	8.00
9.00	00900	HOUSEKEEPING	0	878	0	2,441	0	9.00
10.00	01000	DIETARY	0	11,904	0	0	715	10.00
11.00	01100	CAFETERIA	0	5,060	0	2,816	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,718	0	6,045	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,365	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,009	663	0	110,435	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	3,619	0	395,821	27,230	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	29,301	0	0	81,821	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,063	0	0	94,922	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	1,141	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	2,479	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	12,707	0	0	5,516	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	4,835	0	0	80,865	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,014	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	732	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	22,842	0	0	15,831	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	70,213	1,509	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	2,777	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	2,704	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	47,885	0	2,253	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	1,657	88.01
91.00	09100	EMERGENCY	0	19,185	0	0	1,210	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	66,195	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	5,653	0	6,457	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	245,544	65,248	496,748	551,793	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	11,001	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	245,544	65,248	507,749	551,793	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/14/2017 3:52 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE AND GENERAL	A&G HOSPITAL ONLY	MAINTENANCE & REPAIRS	
			2A	4.00	5.01	5.02	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	107,112	0	107,112			5.01
5.02	00591	A&G HOSPITAL ONLY	11,262	0	3,586	14,848		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	3,231	642	3,873	6.00
7.00	00700	OPERATION OF PLANT	38,950	0	1,481	294	319	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	148	30	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	14,523	0	355	70	93	8.00
9.00	00900	HOUSEKEEPING	3,319	0	1,794	357	14	9.00
10.00	01000	DIETARY	12,619	0	1,775	353	141	10.00
11.00	01100	CAFETERIA	7,876	0	44	9	64	11.00
13.00	01300	NURSING ADMINISTRATION	9,763	0	1,191	237	53	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,365	0	583	116	75	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	117,107	0	2,142	426	81	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	1,474	293	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	426,670	0	9,020	1,793	627	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	111,122	0	2,094	416	346	50.00
53.00	05300	ANESTHESIOLOGY	0	0	3	1	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	116,985	0	4,995	993	261	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	1,141	0	836	166	13	54.01
56.00	05600	RADIOISOTOPE	2,479	0	658	131	29	56.00
58.00	05800	MRI	0	0	500	99	0	58.00
60.00	06000	LABORATORY	18,223	0	8,163	1,622	150	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	262	52	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	79	16	0	64.00
66.00	06600	PHYSICAL THERAPY	85,700	0	4,145	824	57	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,014	0	1,215	242	12	67.00
68.00	06800	SPEECH PATHOLOGY	732	0	141	28	9	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	38,673	0	3,033	603	270	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,957	389	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,722	0	4,227	840	104	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,777	0	1,862	370	43	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	124	25	0	76.01
76.02	03950	DIABETIC EDUCATION	2,704	0	602	120	32	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	50,138	0	21,462	0	749	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,657	0	2,305	0	0	88.01
91.00	09100	EMERGENCY	20,395	0	13,554	2,691	227	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	66,195	0	2,956	588	0	95.00
101.00	10100	HOME HEALTH AGENCY	12,110	0	4,073	0	88	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,359,333	0	106,070	14,836	3,857	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,001	0	61	12	16	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	981	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,370,334	0	107,112	14,848	3,873	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/14/2017 3:52 pm

		Cost Center Description	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	41,044					7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	178				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,426	0	16,467			8.00
9.00	00900	HOUSEKEEPING	216	0	0	5,700		9.00
10.00	01000	DIETARY	2,167	0	0	233	17,288	10.00
11.00	01100	CAFETERIA	985	0	0	106	13,970	11.00
13.00	01300	NURSING ADMINISTRATION	814	0	0	87	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,159	0	0	124	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,094	2	0	134	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	9,671	0	6,100	1,037	2,298	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,334	0	2,662	572	19	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,017	0	2,325	431	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	208	0	0	22	0	54.01
56.00	05600	RADIOISOTOPE	451	0	0	48	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,313	0	14	248	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	880	0	508	94	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	185	0	0	20	0	67.00
68.00	06800	SPEECH PATHOLOGY	133	0	0	14	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,158	0	384	446	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,598	0	0	171	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	10	0	72	957	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	492	0	0	53	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	166	132	1,240	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	6	0	0	88.01
91.00	09100	EMERGENCY	3,493	0	4,185	375	44	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	130	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	10	146	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	40,794	178	16,456	5,673	17,288	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	250	0	0	27	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	11	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	41,044	178	16,467	5,700	17,288	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/14/2017 3:52 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	23,054					11.00
13.00	01300	NURSING ADMINISTRATION	173	12,318				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	372	0	8,794			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	758	0	0	0	121,744	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,069	6,457	0	0	6,761	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	615	1,375	0	0	4,339	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,687	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,553	0	172	0	19,215	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	181	0	9	0	2,440	54.01
56.00	05600	RADIOISOTOPE	66	0	656	0	2,073	56.00
58.00	05800	MRI	7	0	34	0	3,763	58.00
60.00	06000	LABORATORY	2,390	0	3,299	0	23,238	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	528	0	248	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	158	0	1,615	64.00
66.00	06600	PHYSICAL THERAPY	1,089	0	0	0	5,048	66.00
67.00	06700	OCCUPATIONAL THERAPY	339	0	0	0	1,896	67.00
68.00	06800	SPEECH PATHOLOGY	25	0	0	0	71	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	1,117	0	0	0	6,072	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	3,938	0	2,476	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	615	0	0	0	3,036	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	566	1,263	0	0	3,326	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	23	0	0	0	204	76.01
76.02	03950	DIABETIC EDUCATION	191	0	0	0	242	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,507	0	0	0	10,896	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	889	88.01
91.00	09100	EMERGENCY	4,217	3,223	0	0	8,685	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	6,662	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	5,862	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,873	12,318	8,794	0	121,744	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	181	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	23,054	12,318	8,794	0	121,744	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/14/2017 3:52 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
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,767					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		473,503	0	473,503		30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		128,894	0	128,894		50.00
53.00	05300	ANESTHESIOLOGY		2,691	0	2,691		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		150,947	0	150,947		54.00
54.01	05401	RADIOLOGY-ULTRASOUND		5,016	0	5,016		54.01
56.00	05600	RADIOISOTOPE		6,591	0	6,591		56.00
58.00	05800	MRI		4,403	0	4,403		58.00
60.00	06000	LABORATORY		59,660	0	59,660		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		1,090	0	1,090		62.00
64.00	06400	INTRAVENOUS THERAPY		1,868	0	1,868		64.00
66.00	06600	PHYSICAL THERAPY		98,345	0	98,345		66.00
67.00	06700	OCCUPATIONAL THERAPY		4,923	0	4,923		67.00
68.00	06800	SPEECH PATHOLOGY		1,153	0	1,153		68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0		69.00
69.01	03160	CARDIOPULMONARY		54,756	0	54,756		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		8,760	0	8,760		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		82,313	0	82,313		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		11,246	0	11,246		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES		376	0	376		76.01
76.02	03950	DIABETIC EDUCATION		4,436	0	4,436		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		90,290	0	90,290		88.00
88.01	08801	RURAL HEALTH CLINIC II		4,857	0	4,857		88.01
91.00	09100	EMERGENCY		61,089	0	61,089		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		76,531	0	76,531		95.00
101.00	10100	HOME HEALTH AGENCY		22,289	0	22,289		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,356,027	0	1,356,027		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		11,367	0	11,367		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		1,173	0	1,173		192.00
194.00	07950	HOSPICE		0	0	0		194.00
194.01	07951	FAMILY MEDICAL CENTER		0	0	0		194.01
194.02	07952	MEALS ON WHEELS		0	0	0		194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS		0	0	0		194.04
200.00		Cross Foot Adjustments	1,767	1,767	0	1,767		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	1,767	1,370,334	0	1,370,334		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/14/2017 3:52 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	
			1.00	1.01	1.02	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	52,308					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	18,398				1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	0	0	13,523			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				551,686		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	11,240,178	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	11,497	976	0	49,672	854,632	5.01
5.02	00591	A&G HOSPITAL ONLY	603	1,202	111	0	364,402	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	306,323	6.00
7.00	00700	OPERATION OF PLANT	5,297	154	296	2,425	0	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,560	0	110	3,069	28,059	8.00
9.00	00900	HOUSEKEEPING	187	0	65	0	224,147	9.00
10.00	01000	DIETARY	2,536	0	0	715	214,538	10.00
11.00	01100	CAFETERIA	1,078	0	75	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	792	0	161	0	158,290	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,356	0	0	0	59,899	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,280	187	0	110,412	172,042	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	771	0	10,542	27,225	870,703	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,242	0	0	81,805	191,044	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,700	0	0	94,904	464,823	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	243	0	0	0	65,165	54.01
56.00	05600	RADIOISOTOPE	528	0	0	0	27,133	56.00
58.00	05800	MRI	0	0	0	0	855	58.00
60.00	06000	LABORATORY	2,707	0	0	5,515	708,767	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,030	0	0	80,849	463,171	66.00
67.00	06700	OCCUPATIONAL THERAPY	216	0	0	0	161,844	67.00
68.00	06800	SPEECH PATHOLOGY	156	0	0	0	18,834	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,866	0	0	15,828	354,412	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,870	1,509	289,891	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	783	0	0	172,533	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	5,768	76.01
76.02	03950	DIABETIC EDUCATION	576	0	0	0	77,838	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	13,502	0	2,253	2,740,468	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,657	293,141	88.01
91.00	09100	EMERGENCY	4,087	0	0	1,210	959,131	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	66,182	315,154	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,594	0	6,456	530,079	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	52,308	18,398	13,230	551,686	11,093,086	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	293	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	147,092	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	245,544	65,248	507,749	551,793	1,855,626	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.694196	3.546472	37.547068	1.000194	0.165089	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/14/2017 3:52 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	
			1.00	1.01	1.02	2.00	4.00	
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/14/2017 3:52 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			5A.01	5.01	5A.02	5.02	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	-2,067,493	19,180,012				5.01
5.02	00591	A&G HOSPITAL ONLY	0	642,128	-711,346	14,817,630		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	578,439	0	640,791	69,840	6.00
7.00	00700	OPERATION OF PLANT	0	265,167	0	293,750	5,747	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	26,577	0	29,442	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	63,488	0	70,332	1,669	8.00
9.00	00900	HOUSEKEEPING	0	321,178	0	355,799	253	9.00
10.00	01000	DIETARY	0	317,767	0	352,020	2,536	10.00
11.00	01100	CAFETERIA	0	7,876	0	8,725	1,153	11.00
13.00	01300	NURSING ADMINISTRATION	0	213,264	0	236,253	953	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	104,391	0	115,644	1,356	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	383,482	0	424,819	1,467	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	263,871	0	292,315	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,615,110	0	1,789,209	11,313	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	375,012	0	415,436	6,242	50.00
53.00	05300	ANESTHESIOLOGY	0	580	0	643	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	894,287	0	990,686	4,700	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	149,747	0	165,889	243	54.01
56.00	05600	RADIOISOTOPE	0	117,727	0	130,417	528	56.00
58.00	05800	MRI	0	89,544	0	99,196	0	58.00
60.00	06000	LABORATORY	0	1,461,546	0	1,619,092	2,707	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	46,976	0	52,040	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	14,089	0	15,608	0	64.00
66.00	06600	PHYSICAL THERAPY	0	742,176	0	822,178	1,030	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	217,625	0	241,084	216	67.00
68.00	06800	SPEECH PATHOLOGY	0	25,164	0	27,877	156	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	543,000	0	601,532	4,866	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	350,414	0	388,187	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	756,848	0	838,432	1,870	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	333,409	0	369,348	783	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	22,140	0	24,527	0	76.01
76.02	03950	DIABETIC EDUCATION	0	107,830	0	119,453	576	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,844,537	-4,258,955	0	13,502	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	412,736	-457,226	0	0	88.01
91.00	09100	EMERGENCY	0	2,426,773	0	2,688,365	4,087	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	529,299	0	586,354	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	729,252	-807,861	0	1,594	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,067,493	18,993,449	-6,235,388	14,805,443	69,547	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,001	0	12,187	293	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	175,562	-194,487	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		2,067,493		711,346	671,553	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.107794		0.048007	9.615593	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		107,112		14,848	3,873	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.005585		0.001002	0.055455	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/14/2017 3:52 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	48,027					7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	14,472				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,669	0	57,194			8.00
9.00	00900	HOUSEKEEPING	253	0	0	62,171		9.00
10.00	01000	DIETARY	2,536	0	0	2,536	32,078	10.00
11.00	01100	CAFETERIA	1,153	0	0	1,153	25,922	11.00
13.00	01300	NURSING ADMINISTRATION	953	0	0	953	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,356	0	0	1,356	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,280	187	0	1,467	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	11,313	0	21,189	11,313	4,264	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,242	0	9,247	6,242	35	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,700	0	8,075	4,700	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	243	0	0	243	0	54.01
56.00	05600	RADIOISOTOPE	528	0	0	528	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,707	0	48	2,707	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,030	0	1,764	1,030	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	216	0	0	216	0	67.00
68.00	06800	SPEECH PATHOLOGY	156	0	0	156	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,866	0	1,333	4,866	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,870	0	0	1,870	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	783	0	783	1,776	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	576	0	0	576	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	13,502	460	13,502	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	22	0	0	88.01
91.00	09100	EMERGENCY	4,087	0	14,534	4,087	81	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	451	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	34	1,594	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,734	14,472	57,157	61,878	32,078	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	293	0	0	293	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	37	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	363,113	30,855	102,375	377,226	427,865	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.560601	2.132048	1.789960	6.067556	13.338269	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	41,044	178	16,467	5,700	17,288	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.854603	0.012300	0.287915	0.091683	0.538936	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/14/2017 3:52 pm

		Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUISI)	PHARMACY (COSTED REQUISI)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	14,017					11.00
13.00	01300	NURSING ADMINISTRATION	105	69,723				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	226	0	782,464			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	461	0	0	0	37,107,659	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,866	36,549	0	0	2,060,537	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	374	7,783	0	0	1,322,530	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	818,829	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	944	0	15,292	0	5,856,341	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	110	0	812	0	743,711	54.01
56.00	05600	RADIOISOTOPE	40	0	58,337	0	631,767	56.00
58.00	05800	MRI	4	0	3,013	0	1,146,909	58.00
60.00	06000	LABORATORY	1,453	0	293,531	0	7,084,189	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	46,976	0	75,622	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	14,089	0	492,259	64.00
66.00	06600	PHYSICAL THERAPY	662	0	0	0	1,538,635	66.00
67.00	06700	OCCUPATIONAL THERAPY	206	0	0	0	577,999	67.00
68.00	06800	SPEECH PATHOLOGY	15	0	0	0	21,746	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	679	0	0	0	1,850,657	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	350,414	0	754,688	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	374	0	0	0	925,236	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	344	7,149	0	0	1,013,780	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	14	0	0	0	62,045	76.01
76.02	03950	DIABETIC EDUCATION	116	0	0	0	73,700	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,350	0	0	0	3,320,992	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	271,066	88.01
91.00	09100	EMERGENCY	2,564	18,242	0	0	2,647,058	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	2,030,585	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	1,786,778	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,907	69,723	782,464	0	37,107,659	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	110	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	381,699	272,605	158,869	0	490,851	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.231148	3.909829	0.203037	0.000000	0.013228	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	23,054	12,318	8,794	0	121,744	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.644717	0.176671	0.011239	0.000000	0.003281	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/14/2017 3:52 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING		1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00590	ADMINISTRATIVE AND GENERAL		5.01
5.02	00591	A&G HOSPITAL ONLY		5.02
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	OPERATION OF PLANT-CLINIC		7.01
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	54.01
56.00	05600	RADIOISOTOPE	0	56.00
58.00	05800	MRI	0	58.00
60.00	06000	LABORATORY	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
69.01	03160	CARDIOPULMONARY	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	76.01
76.02	03950	DIABETIC EDUCATION	0	76.02
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	88.01
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	HOSPICE	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	194.01
194.02	07952	MEALS ON WHEELS	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	194.04
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	306,348	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,063.480000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,767	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	17.670000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,453,835		2,453,835	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	655,595		655,595	0	0	50.00
53.00	05300	ANESTHESIOLOGY	317,853		317,853	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,268,225		1,268,225	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	192,499		192,499	0	0	54.01
56.00	05600	RADIOISOTOPE	170,242		170,242	0	0	56.00
58.00	05800	MRI	119,850		119,850	0	0	58.00
60.00	06000	LABORATORY	1,952,693		1,952,693	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	65,076		65,076	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	25,730		25,730	0	0	64.00
66.00	06600	PHYSICAL THERAPY	927,126	0	927,126	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	270,935	0	270,935	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	33,537	0	33,537	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	788,870		788,870	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	487,951		487,951	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	944,571		944,571	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	475,446		475,446	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	26,906		26,906	0	0	76.01
76.02	03950	DIABETIC EDUCATION	142,711		142,711	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,635,473		4,635,473	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	460,851		460,851	0	0	88.01
91.00	09100	EMERGENCY	3,115,673		3,115,673	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	353,782		353,782		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	642,171		642,171	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	856,556		856,556		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	21,384,157	0	21,384,157	0	0	200.00
201.00		Less Observation Beds	353,782		353,782		0	201.00
202.00		Total (see instructions)	21,030,375	0	21,030,375	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Hospital | Cost

		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	1,552,321		1,552,321			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,022	1,268,508	1,322,530	0.495713	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	35,092	783,737	818,829	0.388180	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	212,656	5,643,685	5,856,341	0.216556	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	25,188	718,523	743,711	0.258836	0.000000	54.01
56.00	05600	RADIOISOTOPE	2,601	629,166	631,767	0.269470	0.000000	56.00
58.00	05800	MRI	25,943	1,120,966	1,146,909	0.104498	0.000000	58.00
60.00	06000	LABORATORY	495,035	6,589,154	7,084,189	0.275641	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	23,636	51,986	75,622	0.860543	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	25,984	466,275	492,259	0.052269	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	232,713	1,305,922	1,538,635	0.602564	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	198,322	379,677	577,999	0.468746	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	8,093	13,653	21,746	1.542215	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	240,599	1,610,058	1,850,657	0.426265	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	215,715	538,973	754,688	0.646560	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	255,551	669,685	925,236	1.020897	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,013,780	1,013,780	0.468983	0.000000	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	62,045	62,045	0.433653	0.000000	76.01
76.02	03950	DIABETIC EDUCATION	0	73,700	73,700	1.936377	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,320,992	3,320,992			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	271,066	271,066			88.01
91.00	09100	EMERGENCY	13,599	2,633,459	2,647,058	1.177032	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	724	507,492	508,216	0.696125	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	526	2,030,059	2,030,585	0.316249	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,786,778	1,786,778			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	3,618,320	33,489,339	37,107,659			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,618,320	33,489,339	37,107,659			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	03160	CARDIOPULMONARY	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.000000		76.01
76.02	03950	DIABETIC EDUCATION	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/14/2017 3:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,453,835		2,453,835	0	2,453,835	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	655,595		655,595	0	655,595	50.00
53.00	05300	ANESTHESIOLOGY	317,853		317,853	0	317,853	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,268,225		1,268,225	0	1,268,225	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	192,499		192,499	0	192,499	54.01
56.00	05600	RADIOISOTOPE	170,242		170,242	0	170,242	56.00
58.00	05800	MRI	119,850		119,850	0	119,850	58.00
60.00	06000	LABORATORY	1,952,693		1,952,693	0	1,952,693	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	65,076		65,076	0	65,076	62.00
64.00	06400	INTRAVENOUS THERAPY	25,730		25,730	0	25,730	64.00
66.00	06600	PHYSICAL THERAPY	927,126	0	927,126	0	927,126	66.00
67.00	06700	OCCUPATIONAL THERAPY	270,935	0	270,935	0	270,935	67.00
68.00	06800	SPEECH PATHOLOGY	33,537	0	33,537	0	33,537	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	788,870		788,870	0	788,870	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	487,951		487,951	0	487,951	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	944,571		944,571	0	944,571	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	475,446		475,446	0	475,446	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	26,906		26,906	0	26,906	76.01
76.02	03950	DIABETIC EDUCATION	142,711		142,711	0	142,711	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,635,473		4,635,473	0	4,635,473	88.00
88.01	08801	RURAL HEALTH CLINIC II	460,851		460,851	0	460,851	88.01
91.00	09100	EMERGENCY	3,115,673		3,115,673	0	3,115,673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	353,782		353,782		353,782	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	642,171		642,171	0	642,171	95.00
101.00	10100	HOME HEALTH AGENCY	856,556		856,556		856,556	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	21,384,157	0	21,384,157	0	21,384,157	200.00
201.00		Less Observation Beds	353,782		353,782		353,782	201.00
202.00		Total (see instructions)	21,030,375	0	21,030,375	0	21,030,375	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/14/2017 3:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,552,321		1,552,321			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,022	1,268,508	1,322,530	0.495713	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	35,092	783,737	818,829	0.388180	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	212,656	5,643,685	5,856,341	0.216556	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	25,188	718,523	743,711	0.258836	0.000000	54.01
56.00	05600	RADIOISOTOPE	2,601	629,166	631,767	0.269470	0.000000	56.00
58.00	05800	MRI	25,943	1,120,966	1,146,909	0.104498	0.000000	58.00
60.00	06000	LABORATORY	495,035	6,589,154	7,084,189	0.275641	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	23,636	51,986	75,622	0.860543	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	25,984	466,275	492,259	0.052269	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	232,713	1,305,922	1,538,635	0.602564	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	198,322	379,677	577,999	0.468746	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	8,093	13,653	21,746	1.542215	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	240,599	1,610,058	1,850,657	0.426265	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	215,715	538,973	754,688	0.646560	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	255,551	669,685	925,236	1.020897	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,013,780	1,013,780	0.468983	0.000000	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	62,045	62,045	0.433653	0.000000	76.01
76.02	03950	DIABETIC EDUCATION	0	73,700	73,700	1.936377	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,320,992	3,320,992	1.395810	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	271,066	271,066	1.700143	0.000000	88.01
91.00	09100	EMERGENCY	13,599	2,633,459	2,647,058	1.177032	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	724	507,492	508,216	0.696125	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	526	2,030,059	2,030,585	0.316249	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,786,778	1,786,778			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	3,618,320	33,489,339	37,107,659			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,618,320	33,489,339	37,107,659			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/14/2017 3:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	03160	CARDIOPULMONARY	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.000000		76.01
76.02	03950	DIABETIC EDUCATION	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Hospital | Cost

		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	128,894	1,322,530	0.097460	36,797	3,586	50.00
53.00	05300	ANESTHESIOLOGY	2,691	818,829	0.003286	22,263	73	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	150,947	5,856,341	0.025775	120,031	3,094	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	5,016	743,711	0.006745	12,548	85	54.01
56.00	05600	RADIOISOTOPE	6,591	631,767	0.010433	2,019	21	56.00
58.00	05800	MRI	4,403	1,146,909	0.003839	14,753	57	58.00
60.00	06000	LABORATORY	59,660	7,084,189	0.008422	260,302	2,192	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,090	75,622	0.014414	13,684	197	62.00
64.00	06400	INTRAVENOUS THERAPY	1,868	492,259	0.003795	12,863	49	64.00
66.00	06600	PHYSICAL THERAPY	98,345	1,538,635	0.063917	82,331	5,262	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,923	577,999	0.008517	59,588	508	67.00
68.00	06800	SPEECH PATHOLOGY	1,153	21,746	0.053021	4,368	232	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	54,756	1,850,657	0.029587	116,038	3,433	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,760	754,688	0.011607	123,994	1,439	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,313	925,236	0.088964	106,319	9,459	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	11,246	1,013,780	0.011093	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	376	62,045	0.006060	0	0	76.01
76.02	03950	DIABETIC EDUCATION	4,436	73,700	0.060190	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	90,290	3,320,992	0.027188	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,857	271,066	0.017918	0	0	88.01
91.00	09100	EMERGENCY	61,089	2,647,058	0.023078	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	68,267	508,216	0.134327	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	851,971	31,737,975		987,898	29,687	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Hospital | Cost

		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	306,348	0	0	0	306,348	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	306,348	0	0	0	306,348	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Hospital | Cost

		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	1,322,530	0.000000	0.000000	36,797	50.00
53.00	05300	ANESTHESIOLOGY	0	818,829	0.374129	0.000000	22,263	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,856,341	0.000000	0.000000	120,031	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	743,711	0.000000	0.000000	12,548	54.01
56.00	05600	RADIOISOTOPE	0	631,767	0.000000	0.000000	2,019	56.00
58.00	05800	MRI	0	1,146,909	0.000000	0.000000	14,753	58.00
60.00	06000	LABORATORY	0	7,084,189	0.000000	0.000000	260,302	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	75,622	0.000000	0.000000	13,684	62.00
64.00	06400	INTRAVENOUS THERAPY	0	492,259	0.000000	0.000000	12,863	64.00
66.00	06600	PHYSICAL THERAPY	0	1,538,635	0.000000	0.000000	82,331	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	577,999	0.000000	0.000000	59,588	67.00
68.00	06800	SPEECH PATHOLOGY	0	21,746	0.000000	0.000000	4,368	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01	03160	CARDIOPULMONARY	0	1,850,657	0.000000	0.000000	116,038	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	754,688	0.000000	0.000000	123,994	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	925,236	0.000000	0.000000	106,319	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,013,780	0.000000	0.000000	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	62,045	0.000000	0.000000	0	76.01
76.02	03950	DIABETIC EDUCATION	0	73,700	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,320,992	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	271,066	0.000000	0.000000	0	88.01
91.00	09100	EMERGENCY	0	2,647,058	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	508,216	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	31,737,975			987,898	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Hospital | Cost

		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	0	0		50.00
53.00	05300	ANESTHESIOLOGY	8,329	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0		76.01
76.02	03950	DIABETIC EDUCATION	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	8,329	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Hospital | Cost

		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	0.495713	0	580,375	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.388180	0	362,492	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216556	0	2,345,431	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.258836	0	303,451	0	0	54.01
56.00	05600	RADIOISOTOPE	0.269470	0	324,931	0	0	56.00
58.00	05800	MRI	0.104498	0	372,358	0	0	58.00
60.00	06000	LABORATORY	0.275641	0	3,119,671	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.860543	0	34,832	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.052269	0	213,866	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.602564	0	431,935	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.468746	0	56,148	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.542215	0	10,974	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.426265	0	808,771	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.646560	0	230,153	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.020897	0	315,985	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.468983	0	1,013,780	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.433653	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	1.936377	0	46,115	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
91.00	09100	EMERGENCY	1.177032	0	1,050,937	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.696125	0	125,728	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.316249		0			95.00
200.00		Subtotal (see instructions)		0	11,747,933	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	11,747,933	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Hospital | Cost

		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	287,699	0		50.00
53.00	05300	ANESTHESIOLOGY	140,712	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	507,917	0		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	78,544	0		54.01
56.00	05600	RADIOISOTOPE	87,559	0		56.00
58.00	05800	MRI	38,911	0		58.00
60.00	06000	LABORATORY	859,909	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	29,974	0		62.00
64.00	06400	INTRAVENOUS THERAPY	11,179	0		64.00
66.00	06600	PHYSICAL THERAPY	260,268	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	26,319	0		67.00
68.00	06800	SPEECH PATHOLOGY	16,924	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	344,751	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	148,808	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	322,588	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	475,446	0		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0		76.01
76.02	03950	DIABETIC EDUCATION	89,296	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
91.00	09100	EMERGENCY	1,236,986	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	87,522	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,051,312	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,051,312	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1313 | Component CCN: 14-Z313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V | Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Swing Beds - SNF | Cost

		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	0.495713	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.388180	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216556	0	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.258836	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.269470	0	0	0	0	56.00
58.00	05800	MRI	0.104498	0	0	0	0	58.00
60.00	06000	LABORATORY	0.275641	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.860543	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.052269	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.602564	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.468746	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.542215	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.426265	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.646560	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.020897	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.468983	0	0	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.433653	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	1.936377	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
91.00	09100	EMERGENCY	1.177032	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.696125	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.316249		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1313 | Component CCN: 14-Z313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V | Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Swing Beds - SNF | Cost

		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
54.01	05401	RADIOLOGY-ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0		76.01
76.02	03950	DIABETIC EDUCATION	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,166	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	822	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.	11	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	648	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	77	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)	229	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	10	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)	28	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	430	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)	69	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)	207	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)	8	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	144.67	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.50	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,453,835	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)	1,447	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)	4,130	25.00
26.00	Total swing-bed cost (see instructions)	669,732	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,784,103	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	1,061,127	28.00
29.00	Private room charges (excluding swing-bed charges)	23,991	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,037,136	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.681328	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	2,181.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,600.52	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	580.48	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	975.98	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	10,736	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,773,367	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)	2,157.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	927,673	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	7,808	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	935,481	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		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	0	0	0.00	0	0	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)	464,860	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,400,341	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	148,859	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	446,578	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	595,437	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)	163	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,170.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	353,782	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Hospital | Cost

	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	473,503	2,453,835	0.192964	353,782	68,267	90.00
91.00	Nursing School cost	0	2,453,835	0.000000	353,782	0	91.00
92.00	Allied health cost	0	2,453,835	0.000000	353,782	0	92.00
93.00	All other Medical Education	0	2,453,835	0.000000	353,782	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		751,023		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.495713	36,797	18,241	50.00
53.00	05300	ANESTHESIOLOGY	0.388180	22,263	8,642	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216556	120,031	25,993	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.258836	12,548	3,248	54.01
56.00	05600	RADIOISOTOPE	0.269470	2,019	544	56.00
58.00	05800	MRI	0.104498	14,753	1,542	58.00
60.00	06000	LABORATORY	0.275641	260,302	71,750	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.860543	13,684	11,776	62.00
64.00	06400	INTRAVENOUS THERAPY	0.052269	12,863	672	64.00
66.00	06600	PHYSICAL THERAPY	0.602564	82,331	49,610	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.468746	59,588	27,932	67.00
68.00	06800	SPEECH PATHOLOGY	1.542215	4,368	6,736	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.426265	116,038	49,463	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.646560	123,994	80,170	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.020897	106,319	108,541	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.468983	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.433653	0	0	76.01
76.02	03950	DIABETIC EDUCATION	1.936377	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	1.177032	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.696125	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		987,898	464,860	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)		987,898		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1313 | Component CCN: 14-Z313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.495713	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.388180	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216556	8,017	1,736	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.258836	3,507	908	54.01
56.00	05600	RADIOISOTOPE	0.269470	0	0	56.00
58.00	05800	MRI	0.104498	0	0	58.00
60.00	06000	LABORATORY	0.275641	51,098	14,085	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.860543	2,488	2,141	62.00
64.00	06400	INTRAVENOUS THERAPY	0.052269	5,875	307	64.00
66.00	06600	PHYSICAL THERAPY	0.602564	95,193	57,360	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.468746	90,276	42,317	67.00
68.00	06800	SPEECH PATHOLOGY	1.542215	3,056	4,713	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.426265	40,107	17,096	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.646560	36,402	23,536	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.020897	68,503	69,935	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.468983	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.433653	0	0	76.01
76.02	03950	DIABETIC EDUCATION	1.936377	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	1.177032	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.696125	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		404,522	234,134	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)		404,522		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1313	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 2/14/2017 3:52 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,051,312	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,051,312	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,101,825	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	38,675	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,715,429	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)	3,347,721	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)	3,347,721	30.00
31.00	Primary payer payments	457	31.00
32.00	Subtotal (line 30 minus line 31)	3,347,264	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)	201,501	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	130,976	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	184,549	36.00
37.00	Subtotal (see instructions)	3,478,240	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,478,240	40.00
40.01	Sequestration adjustment (see instructions)	69,565	40.01
41.00	Interim payments	3,648,660	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-239,985	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,397,380		3,648,660	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	05/09/2016	47,800		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)		47,800		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)		1,445,180		3,648,660	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		180,236		239,985	6.02
7.00	Total Medicare program liability (see instructions)		1,264,944		3,408,675	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1313 | Component CCN: 14-Z313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		848,731		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	05/09/2016	31,900		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)		31,900		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)		880,631		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		63,309		0	6.02
7.00	Total Medicare program liability (see instructions)		817,322		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1313	Period: From 10/01/2015 To 09/30/2016	Worksheet E-1 Part II Date/Time Prepared: 2/14/2017 3:52 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	213	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	430	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	47	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	659	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	37,107,659	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	59,024	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 14-1313 Component CCN: 14-Z313	Period: From 10/01/2015 To 09/30/2016	Worksheet E-2 Date/Time Prepared: 2/14/2017 3:52 pm
	Title XVIII	Swing Beds - SNF	Cost

		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)	601,391	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)	236,475	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	276	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)	837,866	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	837,866	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)	837,866	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,864	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)	834,002	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	834,002	0	19.00
19.01	Sequestration adjustment (see instructions)	16,680	0	19.01
20.00	Interim payments	880,631	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)	-63,309	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1313	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part V Date/Time Prepared: 2/14/2017 3:52 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,400,341	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,400,341	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,414,344	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,414,344	19.00
20.00	Deductibles (exclude professional component)	140,924	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,273,420	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,273,420	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	26,676	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	17,339	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	25,460	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,290,759	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	1,290,759	30.00
30.01	Sequestration adjustment (see instructions)	25,815	30.01
31.00	Interim payments	1,445,180	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	-180,236	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G | Date/Time Prepared: 2/14/2017 3:52 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	5,620,345	0	0	0	1.00
2.00	Temporary investments	534,177	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,335,936	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	418,752	0	0	0	7.00
8.00	Prepaid expenses	143,026	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11,052,236	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	10,757,798	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	10,757,798	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,371,107	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	4,306,707	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,677,814	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	27,487,848	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	554,852	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,463,329	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	871,077	0	0	0	40.00
41.00	Deferred income	810,220	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	693,206	0	0	0	43.00
44.00	Other current liabilities	311,302	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,703,986	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,805,195	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	5,120,518	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,925,713	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,629,699	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	10,858,149				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)	10,858,149	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	27,487,848	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-1 | Date/Time Prepared: 2/14/2017 3:52 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		10,198,884		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		659,265				2.00
3.00	Total (sum of line 1 and line 2)		10,858,149		0		3.00
4.00		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)		10,858,149		0		11.00
12.00		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)		10,858,149		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			0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00			0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/14/2017 3:52 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,353,356		2,353,356	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,353,356		2,353,356	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	2,353,356		2,353,356	17.00
18.00	Ancillary services	2,096,846	28,586,616	30,683,462	18.00
19.00	Outpatient services	0	1	1	19.00
20.00	RURAL HEALTH CLINIC	0	3,320,992	3,320,992	20.00
20.01	RURAL HEALTH CLINIC II	0	271,066	271,066	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,786,778	1,786,778	22.00
23.00	AMBULANCE SERVICES	526	2,047,725	2,048,251	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00		0	0	0	27.00
27.01		0	0	0	27.01
27.02		0	0	0	27.02
27.03		0	0	0	27.03
27.04		0	0	0	27.04
27.05		0	0	0	27.05
27.06		0	0	0	27.06
27.07		0	0	0	27.07
27.08		0	0	0	27.08
27.09		0	0	0	27.09
27.10		0	0	0	27.10
27.11		0	0	0	27.11
27.12		0	0	0	27.12
27.13		0	0	0	27.13
27.14		0	0	0	27.14
27.16		0	0	0	27.16
27.17		0	0	0	27.17
27.18		0	0	0	27.18
27.21		0	0	0	27.21
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,450,728	36,013,178	40,463,906	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,523,966		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	EMPLOYEE PHYSICALS	5,188			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)		5,188		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		23,518,778		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1313 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-3 | Date/Time Prepared: 2/14/2017 3:52 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	40,463,906	1.00
2.00	Less contractual allowances and discounts on patients' accounts	16,473,095	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,990,811	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,518,778	4.00
5.00	Net income from service to patients (line 3 minus line 4)	472,033	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	184,509	6.00
7.00	Income from investments	79,783	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	872,207	23.00
24.00	OTHER REVENUE	593,155	24.00
24.01	GRANT REVENUE	25,960	24.01
24.02	ELECTRONIC HEALTH RECORDS INCENTIVE	51,062	24.02
24.03	FITNESS REVENUE	6,356	24.03
24.04	RESPIRATORY THERAPY SERVICES	600	24.04
25.00	Total other income (sum of lines 6-24)	1,813,632	25.00
26.00	Total (line 5 plus line 25)	2,285,665	26.00
27.00	BAD DEBTS	1,492,367	27.00
27.01	CHARITY CARE	57,612	27.01
27.02	DIABETIC PROGRAM	76,420	27.02
27.03	ROUNDING	1	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	1,626,400	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	659,265	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H | Date/Time Prepared: 2/14/2017 3:52 pm

Home Health Agency I | PPS

		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	141,908	10,244	36,527	0	29,062	217,741	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	362,476	26,165	0	0	0	388,641	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	25,695	1,855	0	0	0	27,550	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	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	530,079	38,264	36,527	0	29,062	633,932	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	0	217,741	-4,300	213,441			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	388,641	0	388,641			6.00
7.00	Physical Therapy	0	0	0	0			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	27,550	0	27,550			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	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	633,932	-4,300	629,632			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: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-1 Part I | Date/Time Prepared: 2/14/2017 3:52 pm

Home Health Agency I | PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: 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	213,441	0	0	0	0	213,441	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	388,641	0	0	0	0	388,641	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	27,550	0	0	0	0	27,550	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	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	629,632	0	0	0	0	629,632	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	213,441			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	199,312	587,953		6.00
7.00	Physical Therapy	0	0		7.00
8.00	Occupational Therapy	0	0		8.00
9.00	Speech Pathology	0	0		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Home Health Aide	14,129	41,679		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)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		629,632		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-1 Part II Date/Time Prepared: 2/14/2017 3:52 pm

Home Health Agency I | PPS

		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	-213,441	416,191	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	388,641	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	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	27,550	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	0	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	-213,441	416,191	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		213,441	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.512844	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-2 Part I | Date/Time Prepared: 2/14/2017 3:52 pm

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	1.01	1.02	2.00	4.00	
1.00	Administrative and General	0	0	5,653	0	6,457	87,510	1.00
2.00	Skilled Nursing Care	587,953	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	41,679	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)	629,632	0	5,653	0	6,457	87,510	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	ADMINISTRATIVE AND GENERAL	Subtotal	A&G HOSPITAL ONLY	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		4A	5.01	5A.01	5.02	6.00	7.00	
1.00	Administrative and General	99,620	10,738	110,358	0	15,327	0	1.00
2.00	Skilled Nursing Care	587,953	63,378	651,331	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	41,679	4,493	46,172	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)	729,252	78,609	807,861	0	15,327	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.	0.000000		0.000000				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: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-2 Part I | Date/Time Prepared: 2/14/2017 3:52 pm

Home Health Agency I | PPS

	Cost Center Description	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.01	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	61	9,672	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	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)	0	61	9,672	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	19.00	24.00	25.00	
1.00	Administrative and General	0	0	23,635	0	159,053	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	651,331	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	46,172	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)	0	0	23,635	0	856,556	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-2 Part I | Date/Time Prepared: 2/14/2017 3:52 pm

Home Health Agency I | PPS

	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	159,053					1.00
2.00	Skilled Nursing Care	651,331	148,524	799,855			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	46,172	10,529	56,701			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) (2)	856,556	159,053	856,556			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.		0.228032				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: 14-1313
HHA CCN: 14-7202

Period: From 10/01/2015 To 09/30/2016

Worksheet H-2 Part II
Date/Time Prepared: 2/14/2017 3:52 pm

Home Health Agency I

PPS

	Cost Center Description	CAPITAL RELATED COSTS						
		BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	
		1.00	1.01	1.02	2.00	4.00	5A.01	
1.00	Administrative and General	0	1,594	0	6,456	530,079	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)	0	1,594	0	6,456	530,079		20.00
21.00	Total cost to be allocated	0	5,653	0	6,457	87,510		21.00
22.00	Unit cost multiplier	0.000000	3.546424	0.000000	1.000155	0.165089		22.00

	Cost Center Description	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	
		5.01	5A.02	5.02	6.00	7.00	7.01	
1.00	Administrative and General	99,620	-110,358	0	1,594	0	0	1.00
2.00	Skilled Nursing Care	587,953	-651,331	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	41,679	-46,172	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)	729,252		0	1,594	0	0	20.00
21.00	Total cost to be allocated	78,609		0	15,327	0	0	21.00
22.00	Unit cost multiplier	0.107794		0.000000	9.615433	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-2 Part II | Date/Time Prepared: 2/14/2017 3:52 pm

Home Health Agency I | PPS

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UISI)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	34	1,594	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	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)	34	1,594	0	0	0	0	20.00
21.00	Total cost to be allocated	61	9,672	0	0	0	0	21.00
22.00	Unit cost multiplier	1.794118	6.067754	0.000000	0.000000	0.000000	0.000000	22.00

	Cost Center Description	PHARMACY (COSTED REQ UISI)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)				
		15.00	16.00	19.00				
1.00	Administrative and General	0	1,786,778	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)	0	1,786,778	0				20.00
21.00	Total cost to be allocated	0	23,635	0				21.00
22.00	Unit cost multiplier	0.000000	0.013228	0.000000				22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-1313 HHA CCN: 14-7202 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-3 Part I Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	799,855		799,855	9,971	80.22	1.00
2.00	Physical Therapy	3.00	0	250,394	250,394	3,923	63.83	2.00
3.00	Occupational Therapy	4.00	0	89,165	89,165	2,199	40.55	3.00
4.00	Speech Pathology	5.00	0	25,135	25,135	153	164.28	4.00
5.00	Medical Social Services	6.00	0		0	27	0.00	5.00
6.00	Home Health Aide	7.00	56,701		56,701	1,462	38.78	6.00
7.00	Total (sum of lines 1-6)		856,556	364,694	1,221,250	17,735		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	2,849			8.00
8.01	Skilled Nursing Care		99917	0	8			8.01
9.00	Physical Therapy		99914	0	1,001			9.00
9.01	Physical Therapy		99917	0	5			9.01
10.00	Occupational Therapy		99914	0	476			10.00
10.01	Occupational Therapy		99917	0	1			10.01
11.00	Speech Pathology		99914	0	42			11.00
11.01	Speech Pathology		99917	0	0			11.01
12.00	Medical Social Services		99914	0	6			12.00
12.01	Medical Social Services		99917	0	0			12.01
13.00	Home Health Aide		99914	0	278			13.00
13.01	Home Health Aide		99917	0	0			13.01
14.00	Total (sum of lines 8-13)			0	4,666			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	9,643	9,643	14,915	0.646530	15.00
16.00	Cost of Drugs	9.00	0	258	258	253	1.019763	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	2,857		0	229,189		1.00
2.00	Physical Therapy	0	1,006		0	64,213		2.00
3.00	Occupational Therapy	0	477		0	19,342		3.00
4.00	Speech Pathology	0	42		0	6,900		4.00
5.00	Medical Social Services	0	6		0	0		5.00
6.00	Home Health Aide	0	278		0	10,781		6.00
7.00	Total (sum of lines 1-6)	0	4,666		0	330,425		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1313 HHA CCN: 14-7202 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-3 Part I Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Home Health Agency I | PPS

	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
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		205	0		209	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	229,189	1.00
2.00	Physical Therapy	64,213	2.00
3.00	Occupational Therapy	19,342	3.00
4.00	Speech Pathology	6,900	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	10,781	6.00
7.00	Total (sum of lines 1-6)	330,425	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-3 Part II | Date/Time Prepared: 2/14/2017 3:52 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	0.602564	415,547	250,394	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.468746	190,221	89,165	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	1.542215	16,298	25,135	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.646560	14,915	9,643	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	1.020897	253	258	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B 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	209	0	1.00
2.00	Total charges	0	205	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	205	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	4	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	209	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	567,106	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	23,738	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	10,070	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	2,165	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	2,859	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	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	606,147	22.00
23.00	Excess reasonable cost (from line 8)	0	4	23.00
24.00	Subtotal (line 22 minus line 23)	0	606,143	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	606,143	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	606,143	29.00
30.00	OTHER ADJUSTMENTS (FROM PS&R)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	606,143	31.00
31.01	Sequestration adjustment (see instructions)	0	12,119	31.01
32.00	Interim payments (see instructions)	0	593,935	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	89	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 HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-5 | Date/Time Prepared: 2/14/2017 3:52 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		593,935	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		593,935	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		89	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		594,024	7.00

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

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313 | Component CCN: 14-3457 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1 | Date/Time Prepared: 2/14/2017 3:52 pm

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	1,614,314	0	1,614,314	-113,063	1,501,251	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	385,538	0	385,538	0	385,538	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	506,430	0	506,430	0	506,430	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)	2,506,282	0	2,506,282	-113,063	2,393,219	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	15,312	15,312	0	15,312	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	15,312	15,312	0	15,312	14.00
15.00	Medical Supplies	0	133,078	133,078	0	133,078	15.00
16.00	Transportation (Health Care Staff)	0	2,139	2,139	0	2,139	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	64,219	64,219	0	64,219	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	199,436	199,436	0	199,436	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,506,282	214,748	2,721,030	-113,063	2,607,967	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						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	6,092	6,092	0	6,092	29.00
30.00	Administrative Costs	347,249	380,827	728,076	0	728,076	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	347,249	386,919	734,168	0	734,168	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,853,531	601,667	3,455,198	-113,063	3,342,135	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313 | Component CCN: 14-3457 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1 | Date/Time Prepared: 2/14/2017 3:52 pm

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	1,501,251		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	385,538		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	506,430		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	2,393,219		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	15,312		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	15,312		14.00
15.00	Medical Supplies	0	133,078		15.00
16.00	Transportation (Health Care Staff)	0	2,139		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	64,219		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	199,436		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,607,967		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	6,092		29.00
30.00	Administrative Costs	-156	727,920		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-156	734,012		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-156	3,341,979		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313 | Component CCN: 14-3462 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1 | Date/Time Prepared: 2/14/2017 3:52 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	33,256	0	33,256	0	33,256	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	154,036	0	154,036	0	154,036	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	55,013	0	55,013	0	55,013	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)	242,305	0	242,305	0	242,305	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	2,677	2,677	0	2,677	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	2,677	2,677	0	2,677	14.00
15.00	Medical Supplies	0	5,723	5,723	0	5,723	15.00
16.00	Transportation (Health Care Staff)	0	3,270	3,270	0	3,270	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	8,993	8,993	0	8,993	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	242,305	11,670	253,975	0	253,975	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						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	7,402	7,402	0	7,402	29.00
30.00	Administrative Costs	50,836	50,472	101,308	0	101,308	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	50,836	57,874	108,710	0	108,710	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	293,141	69,544	362,685	0	362,685	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313 | Component CCN: 14-3462 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1 | Date/Time Prepared: 2/14/2017 3:52 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	33,256		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	154,036		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	55,013		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	242,305		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	2,677		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	2,677		14.00
15.00	Medical Supplies	0	5,723		15.00
16.00	Transportation (Health Care Staff)	0	3,270		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	8,993		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	253,975		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	7,402		29.00
30.00	Administrative Costs	0	101,308		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	108,710		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	362,685		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1313 | Component CCN: 14-3457 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-2 | Date/Time Prepared: 2/14/2017 3:52 pm

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	1.99	8,654	4,200	8,358		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.06	4,563	2,100	4,326		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.05	13,217		12,684	13,217	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	0.95	1,155			1,155	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)	5.00	14,372			14,372	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,607,967	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)					2,607,967	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					734,012	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,293,494	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,027,506	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,027,506	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,027,506	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,635,473	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1313 Component CCN: 14-3462

Period: From 10/01/2015 To 09/30/2016

Worksheet M-2

Date/Time Prepared: 2/14/2017 3:52 pm

RHC II

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.12	506	4,200	504		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.52	1,388	2,100	1,092		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.64	1,894		1,596	1,894	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.64	1,894			1,894	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					253,975	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)					253,975	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					108,710	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					98,166	15.00
16.00	Total overhead (sum of lines 14 and 15)					206,876	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					206,876	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					206,876	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					460,851	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1313 Component CCN: 14-3457	Period: From 10/01/2015 To 09/30/2016	Worksheet M-3 Date/Time Prepared: 2/14/2017 3:52 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			4,635,473	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			37,200	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			4,598,273	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			14,372	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)			14,372	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			319.95	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)	319.95	319.95		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,670		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,494,167		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,494,167		16.00
16.01	Total program charges (see instructions)(from contractor's records)		849,770		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		19,961		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		35,098		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.)		1,105,997		16.04
16.05	Total program cost (see instructions)	0	1,141,095		16.05
17.00	Primary payer amounts		71		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		76,573		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		150,647		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,141,024		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		22,134		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,163,158		22.00
23.00	Allowable bad debts (see instructions)		36,273		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		23,577		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		36,273		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
26.00	Net reimbursable amount (see instructions)		1,186,735		26.00
26.01	Sequestration adjustment (see instructions)		23,735		26.01
27.00	Interim payments		1,097,767		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)		65,233		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1313 Component CCN: 14-3462	Period: From 10/01/2015 To 09/30/2016	Worksheet M-3 Date/Time Prepared: 2/14/2017 3:52 pm
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			460,851	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			1,633	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			459,218	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,894	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)			1,894	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			242.46	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)	242.46	242.46		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	253		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	61,342		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	61,342		16.00
16.01	Total program charges (see instructions)(from contractor's records)		43,960		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		630		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		879		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.)		44,886		16.04
16.05	Total program cost (see instructions)	0	45,765		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,356		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		7,795		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		45,765		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		758		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		46,523		22.00
23.00	Allowable bad debts (see instructions)		1,406		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		914		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,406		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)		47,437		26.00
26.01	Sequestration adjustment (see instructions)		949		26.01
27.00	Interim payments		44,987		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)		1,501		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 14-1313 | Component CCN: 14-3457 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-4 | Date/Time Prepared: 2/14/2017 3:52 pm

Title XVIII | RHC I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,393,219	2,393,219	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000231	0.002783	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	553	6,660	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	3,787	9,929	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	4,340	16,589	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,607,967	2,607,967	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,027,506	2,027,506	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001664	0.006361	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	3,374	12,897	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	7,714	29,486	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	46	555	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	167.70	53.13	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	23	344	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,857	18,277	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)		37,200	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)		22,134	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-1313 Component CCN: 14-3462	Period: From 10/01/2015 To 09/30/2016	Worksheet M-4 Date/Time Prepared: 2/14/2017 3:52 pm
	Title XVIII	RHC II	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	242,305	242,305	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000041	0.001194	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	10	289	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	82	519	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	92	808	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	253,975	253,975	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	206,876	206,876	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000362	0.003181	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	75	658	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	167	1,466	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	1	29	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	167.00	50.55	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	15	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	758	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)		1,633	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)		758	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1313 Component CCN: 14-3457	Period: From 10/01/2015 To 09/30/2016	Worksheet M-5 Date/Time Prepared: 2/14/2017 3:52 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,056,367	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		05/09/2016	41,400	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)		41,400	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,097,767	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		65,233	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,163,000	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-1313 | Component CCN: 14-3462 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-5 | Date/Time Prepared: 2/14/2017 3:52 pm

RHC II | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		44,987	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		44,987	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		1,501	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		46,488	7.00

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