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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141319	Period: From 06/01/2015 To 05/31/2016	Worksheet S Parts I-III Date/Time Prepared: 10/17/2016 10:48 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 10/17/2016 Time: 10:48 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HAMMOND-HENRY HOSPITAL (141319) for the cost reporting period beginning 06/01/2015 and ending 05/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	242,623	-49,203	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	-2,994	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	-18		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
200.00	Total	0	239,629	-49,221	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 10/10/2016 4:39 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 600 N. COLLEGE AVENUE	PO Box:			1.00
2.00	City: GENESEO	State: IL	Zip Code: 61254-1099	County: HENRY	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	HAMMOND-HENRY HOSPITAL	141319	99914	1	06/04/2002	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	HAMMOND-HENRY SWING BED	14Z319	99914		05/21/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	HAMMOND-HENRY SKILLED NURSING	145464	99914		06/01/1983	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HAMMOND-HENRY HOME HEALTH SERVICES	147450	99914		06/05/1986	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									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
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)	06/01/2015	05/31/2016	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.	2	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: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 10/10/2016 4:39 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)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 10/10/2016 4:39 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: 141319	Period: From 06/01/2015 To 05/31/2016	Worksheet S-2 Part I Date/Time Prepared: 10/10/2016 4:39 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.	Y	N	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

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	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.	N		108.00

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

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	491,753	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.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	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: 141319	Period: From 06/01/2015 To 05/31/2016	Worksheet S-2 Part I Date/Time Prepared: 10/10/2016 4:39 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
161.10	CORF		N	N	N	161.10

		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: 141319	Period: From 06/01/2015 To 05/31/2016	Worksheet S-2 Part I Date/Time Prepared: 10/10/2016 4:39 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)	10/01/2015	12/31/2015	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 10/10/2016 4:39 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	08/05/2016	Y	08/05/2016	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: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 10/10/2016 4:39 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	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.	Y	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: 141319	Period: From 06/01/2015 To 05/31/2016	Worksheet S-2 Part II Date/Time Prepared: 10/10/2016 4:39 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: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 10/10/2016 4:39 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	85,920.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	85,920.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,150	85,920.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	37	13,542		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	0	0			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
25.10	CMHC - CORF	99.10				0	25.10
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		62				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: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 10/10/2016 4:39 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,649	142	3,580			1.00
2.00	HMO and other (see instructions)	193	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	185	0	199			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,834	142	3,779			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		94	450			13.00
14.00	Total (see instructions)	1,834	236	4,229	0.00	203.16	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	1,171	0	12,209	0.00	23.52	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			0	0.00	0.00	21.00
22.00	HOME HEALTH AGENCY	6,442	0	9,223	0.00	8.36	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
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	235.04	27.00
28.00	Observation Bed Days		0	488			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			81			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 10/10/2016 4:39 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	496	349	1,240	1.00
2.00	HMO and other (see instructions)			60	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	496	349	1,240	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00				0	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
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 141319 | Component CCN: 147450 | Period: From 06/01/2015 To 05/31/2016 | Worksheet S-4 | Date/Time Prepared: 10/10/2016 4:39 pm

Home Health Agency I | PPS

						1.00	
0.00	County				HENRY		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	13,556	0	0	13,556	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	268.00	0.00	0.00	268.00	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	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.84	0.00	0.84	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			1.00	0.00	1.00	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			6.52	0.00	6.52	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).			19340			20.00
20.01				99914			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	3,067	191	117	25	3,400	21.00
22.00	Skilled Nursing Visit Charges	431,251	27,249	16,551	3,380	478,431	22.00
23.00	Physical Therapy Visits	1,111	21	10	8	1,150	23.00
24.00	Physical Therapy Visit Charges	195,827	3,567	1,720	1,359	202,473	24.00
25.00	Occupational Therapy Visits	573	30	6	14	623	25.00
26.00	Occupational Therapy Visit Charges	99,952	5,096	1,040	2,378	108,466	26.00
27.00	Speech Pathology Visits	146	27	1	0	174	27.00
28.00	Speech Pathology Visit Charges	25,519	4,840	170	0	30,529	28.00
29.00	Medical Social Service Visits	11	4	0	0	15	29.00
30.00	Medical Social Service Visit Charges	2,472	863	0	0	3,335	30.00
31.00	Home Health Aide Visits	930	150	0	0	1,080	31.00
32.00	Home Health Aide Visit Charges	70,283	11,402	0	0	81,685	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,838	423	134	47	6,442	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)	825,304	53,017	19,481	7,117	904,919	35.00
36.00	Total Number of Episodes (standard/non outlier)	343		44	4	391	36.00
37.00	Total Number of Outlier Episodes		10		0	10	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet S-7 | Date/Time Prepared: 10/10/2016 4:39 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	05/21/2003	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	27	0	27	12.00
13.00		RUB	23	0	23	13.00
14.00		RUA	50	0	50	14.00
15.00		RVC	94	0	94	15.00
16.00		RVB	161	0	161	16.00
17.00		RVA	451	0	451	17.00
18.00		RHC	34	0	34	18.00
19.00		RHB	73	0	73	19.00
20.00		RHA	130	0	130	20.00
21.00		RMC	21	0	21	21.00
22.00		RMB	59	0	59	22.00
23.00		RMA	25	0	25	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	16	0	16	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	3	0	3	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	4	0	4	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet S-7 | Date/Time Prepared: 10/10/2016 4:39 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	419	419	199.00
200.00	TOTAL		1,171	419	1,590	200.00

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

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	819,587	34.02	Y	202.00
203.00	Recruitment	0	0.00	N	203.00
204.00	Retention of employees	0	0.00	N	204.00
205.00	Training	1,274	0.05	N	205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	2,409,232			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141319	Period: From 06/01/2015 To 05/31/2016	Worksheet S-10 Date/Time Prepared: 10/10/2016 4:39 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)	0.409298	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	639,750	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	693,641	5.00
6.00	Medicaid charges	2,163,090	6.00
7.00	Medicaid cost (line 1 times line 6)	885,348	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
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	82,913	269,883	352,796	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	33,936	110,463	144,399	21.00
22.00	Partial payment by patients approved for charity care	749	46,473	47,222	22.00
23.00	Cost of charity care (line 21 minus line 22)	33,187	63,990	97,177	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)	1,091,764	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	47,280	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,044,484	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	427,505	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	524,682	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	524,682	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet A | Date/Time Prepared: 10/10/2016 4:39 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		2,094,352	2,094,352	897,228	2,991,580	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,194,503	1,194,503	17,017	1,211,520	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	94,730	6,893,212	6,987,942	0	6,987,942	4.00
5.01	00550	DATA PROCESSING	349,715	288,471	638,186	0	638,186	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	117,029	4,380	121,409	0	121,409	5.02
5.03	00570	ADMITTING	151,292	55,301	206,593	0	206,593	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	295,098	332,143	627,241	-82,220	545,021	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GENERAL	466,967	1,908,606	2,375,573	37	2,375,610	5.05
7.00	00700	OPERATION OF PLANT	200,792	862,190	1,062,982	0	1,062,982	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,057	97,493	127,550	0	127,550	8.00
9.00	00900	HOUSEKEEPING	356,244	107,787	464,031	0	464,031	9.00
10.00	01000	DIETARY	444,931	397,136	842,067	0	842,067	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	306,206	76,117	382,323	0	382,323	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	64,759	64,759	0	64,759	14.00
15.00	01500	PHARMACY	202,064	220,675	422,739	0	422,739	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	340,672	64,506	405,178	0	405,178	16.00
17.00	01700	SOCIAL SERVICE	124,664	908	125,572	0	125,572	17.00
18.00	01080	INSERVICE EDUCATION	95,540	39,928	135,468	0	135,468	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,040,619	193,017	2,233,636	-156,503	2,077,133	30.00
43.00	04300	NURSERY	98	7,546	7,644	92,776	100,420	43.00
44.00	04400	SKILLED NURSING FACILITY	861,149	62,785	923,934	0	923,934	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,195,954	2,649,001	3,844,955	-1,394,607	2,450,348	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	63,727	63,727	52.00
53.00	05300	ANESTHESIOLOGY	701,298	97,619	798,917	-97,619	701,298	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	752,683	1,276,026	2,028,709	3,410	2,032,119	54.00
60.00	06000	LABORATORY	633,075	835,905	1,468,980	0	1,468,980	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	110,573	110,573	0	110,573	62.00
64.00	06400	INTRAVENOUS THERAPY	0	3,182	3,182	0	3,182	64.00
66.00	06600	PHYSICAL THERAPY	1,065,122	58,421	1,123,543	0	1,123,543	66.00
67.00	06700	OCCUPATIONAL THERAPY	388,373	25,689	414,062	0	414,062	67.00
68.00	06800	SPEECH PATHOLOGY	85,979	6,324	92,303	0	92,303	68.00
69.00	06900	ELECTROCARDIOLOGY	232,734	201,475	434,209	0	434,209	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,492,226	1,492,226	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	972,534	972,534	0	972,534	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	65,961	64,229	130,190	0	130,190	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	611,805	218,038	829,843	38,958	868,801	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	39,177	1,850,588	1,889,765	0	1,889,765	90.03
91.00	09100	EMERGENCY	535,867	1,561,553	2,097,420	0	2,097,420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	469,719	102,324	572,043	0	572,043	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		874,430	874,430	-874,430	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,255,614	25,873,726	39,129,340	0	39,129,340	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	110,738	110,738	0	110,738	192.01
192.02	19201	CARDIOLOGY CLINIC	0	2,522	2,522	0	2,522	192.02
192.03	19202	LEASED SPACE	19,180	74,692	93,872	0	93,872	192.03
194.00	07955	FOUNDATION	0	0	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	114,377	30,799	145,176	0	145,176	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
200.00		TOTAL (SUM OF LINES 118-199)	13,389,171	26,092,477	39,481,648	0	39,481,648	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet A | Date/Time Prepared: 10/10/2016 4:39 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	42,469	3,034,049		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-129,398	1,082,122		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,031,332	3,956,610		4.00
5.01	00550	DATA PROCESSING	0	638,186		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-2,069	119,340		5.02
5.03	00570	ADMITTING	0	206,593		5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	545,021		5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GENERAL	-159,903	2,215,707		5.05
7.00	00700	OPERATION OF PLANT	0	1,062,982		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	127,550		8.00
9.00	00900	HOUSEKEEPING	0	464,031		9.00
10.00	01000	DIETARY	-181,238	660,829		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	382,323		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	64,759		14.00
15.00	01500	PHARMACY	0	422,739		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,629	403,549		16.00
17.00	01700	SOCIAL SERVICE	0	125,572		17.00
18.00	01080	INSERVICE EDUCATION	0	135,468		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,077,133		30.00
43.00	04300	NURSERY	0	100,420		43.00
44.00	04400	SKILLED NURSING FACILITY	502	924,436		44.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-14,100	2,436,248		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	63,727		52.00
53.00	05300	ANESTHESIOLOGY	-701,298	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,409	2,028,710		54.00
60.00	06000	LABORATORY	0	1,468,980		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	110,573		62.00
64.00	06400	INTRAVENOUS THERAPY	0	3,182		64.00
66.00	06600	PHYSICAL THERAPY	0	1,123,543		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	414,062		67.00
68.00	06800	SPEECH PATHOLOGY	0	92,303		68.00
69.00	06900	ELECTROCARDIOLOGY	-21,558	412,651		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,492,226		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	972,534		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	130,190		76.01
76.02	03950	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	-373,592	495,209		90.00
90.01	09001	OB CLINIC	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
90.03	09003	SURGICAL CLINIC	-1,277,426	612,339		90.03
91.00	09100	EMERGENCY	-502,542	1,594,878		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	572,043		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,356,523	32,772,817		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19203	MUSCATINE CLINIC	0	110,738		192.01
192.02	19201	CARDIOLOGY CLINIC	0	2,522		192.02
192.03	19202	LEASED SPACE	0	93,872		192.03
194.00	07955	FOUNDATION	0	0		194.00
194.01	07950	SPORTS MEDICINE	0	145,176		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0		194.02
194.03	07952	ANESTHESIA BILLNG	0	0		194.03
194.04	07953	SPECIALTY CLINIC	0	0		194.04
194.05	07954	COLONA CLINIC	0	0		194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0		194.06
200.00		TOTAL (SUM OF LINES 118-199)	-6,356,523	33,125,125		200.00

RECLASSIFICATIONS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet A-6 | Date/Time Prepared: 10/10/2016 4:39 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - COLONA CLINIC BUILDING DEPRECIATION					
1.00	CLINIC	90.00	0	38,958		1.00
	TOTALS		0	38,958		
	C - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	870,983		1.00
	TOTALS		0	870,983		
	D - CAPITAL LEASE INTEREST					
1.00	ALL OTHER ADMINISTRATIVE AND GENERAL	5.05	0	37		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,410		2.00
	TOTALS		0	3,447		
	E - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	65,203		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	17,017		2.00
	TOTALS		0	82,220		
	F - DELIVERY AND LABOR RECLASS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	63,727	0		1.00
	TOTALS		63,727	0		
	G - RECLASS ALLOWABLE ANESTHESIA EXPENSE					
1.00	OPERATING ROOM	50.00	0	97,619		1.00
	TOTALS		0	97,619		
	H - IMPLANT EXP RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,492,226		1.00
	TOTALS		0	1,492,226		
	I - NURSERY RECLASS					
1.00	NURSERY	43.00	92,776	0		1.00
	TOTALS		92,776	0		
500.00	Grand Total: Increases		156,503	2,585,453		500.00

RECLASSIFICATIONS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet A-6 | Date/Time Prepared: 10/10/2016 4:39 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - COLONA CLINIC BUILDING DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	38,958	9		1.00
	TOTALS		0	38,958			
	C - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	870,983	11		1.00
	TOTALS		0	870,983			
	D - CAPITAL LEASE INTEREST						
1.00	INTEREST EXPENSE	113.00	0	3,447	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	3,447			
	E - OTHER CAPITAL COSTS						
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	82,220	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	82,220			
	F - DELIVERY AND LABOR RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	63,727	0	0		1.00
	TOTALS		63,727	0			
	G - RECLASS ALLOWABLE ANESTHESIA EXPENSE						
1.00	ANESTHESIOLOGY	53.00	0	97,619	0		1.00
	TOTALS		0	97,619			
	H - IMPLANT EXP RECLASS						
1.00	OPERATING ROOM	50.00	0	1,492,226	0		1.00
	TOTALS		0	1,492,226			
	I - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	92,776	0	0		1.00
	TOTALS		92,776	0			
500.00	Grand Total: Decreases		156,503	2,585,453			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 10/10/2016 4:39 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	1,299,659	17,010	0	17,010	0	1.00
2.00	Land Improvements	1,371,025	61,513	168,663	230,176	0	2.00
3.00	Buildings and Fixtures	44,712,705	140,507	1,529	142,036	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	12,292,402	726,158	19,569	745,727	570,060	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	59,675,791	945,188	189,761	1,134,949	570,060	8.00
9.00	Reconciling Items	-183,530	-131,502	189,761	58,259	0	9.00
10.00	Total (line 8 minus line 9)	59,859,321	1,076,690	0	1,076,690	570,060	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,316,669	0	1.00
2.00	Land Improvements	1,601,201	0	2.00
3.00	Buildings and Fixtures	44,854,741	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	12,468,069	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	60,240,680	0	8.00
9.00	Reconciling Items	-125,271	0	9.00
10.00	Total (line 8 minus line 9)	60,365,951	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 10/10/2016 4:39 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	2,094,352	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,194,503	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,288,855	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	2,094,352		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,194,503		2.00
3.00	Total (sum of lines 1-2)	0	3,288,855		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 10/10/2016 4:39 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	47,772,611	0	47,772,611	0.793029	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12,468,069	0	12,468,069	0.206971	0	2.00
3.00	Total (sum of lines 1-2)	60,240,680	0	60,240,680	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	2,055,394	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,065,105	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,120,499	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	913,452	65,203	0	0	3,034,049	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	17,017	0	0	1,082,122	2.00
3.00	Total (sum of lines 1-2)	913,452	82,220	0	0	4,116,171	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet A-8 | Date/Time Prepared: 10/10/2016 4:39 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
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	-2,189,218			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
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet A-8 | Date/Time Prepared: 10/10/2016 4:39 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	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-127,167	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	CAFETERIA-EMPLOYEES AND GUESTS	B	-172,965	DIETARY	10.00	0	33.00
33.01	SALE OF MEDICAL RECORDS AND ABSTRACT	B	-1,629	MEDICAL RECORDS & LIBRARY	16.00	0	33.01
33.02			0		0.00	0	33.02
33.03	DIETARY RECEIPTS - OTHER	B	-8,273	DIETARY	10.00	0	33.03
33.04	SUPPLIES REBATES	B	-1,971	PURCHASING RECEIVING AND STORES	5.02	0	33.04
33.05			0		0.00	0	33.05
33.06	A/P REVENUE	B	-98	PURCHASING RECEIVING AND STORES	5.02	0	33.06
33.07			0		0.00	0	33.07
33.08			0		0.00	0	33.08
33.09			0		0.00	0	33.09
33.10	FOUNDATION EXPENSES	B	-96,032	ALL OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.10
33.11	ADVERTISING EXPENSE	B	-63,200	ALL OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.11
33.12	CRNA EXPENSE	B	-701,298	ANESTHESIOLOGY	53.00	0	33.12
33.13	CRNA FRINGES	B	-168,571	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	LTC OTHER REVENUE	B	502	SKILLED NURSING FACILITY	44.00	0	33.14
33.15	CABLE TV	A	-2,231	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.15
33.16	TELEPHONE SERVICES	A	-634	ALL OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.16
33.17	UNNECESSARY BORROWING - CAP LEASE	A	-37	ALL OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.17
33.18	UNNECESSARY BORROWING - CAP LEASE	A	-3,409	RADIOLOGY-DIAGNOSTIC	54.00	0	33.18
33.19	PHYSICIAN BENEFIT OFFSET	A	-82,216	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.19
33.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.20
33.21	UNAMMORTIZED BOND ISSUE COST	B	31,790	CAP REL COSTS-BLDG & FIXT	1.00	11	33.21
33.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.22
33.23	UNAMMORTIZED BOND ISSUE COST	B	10,679	CAP REL COSTS-BLDG & FIXT	1.00	11	33.23
33.24	IMRF CONTRIBUTION	A	-2,780,545	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.24
33.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.25
33.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.26
33.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.27
33.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.28
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,356,523				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: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 10/10/2016 4:39 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	60.00	LABORATORY	37,516	0	37,516	0	0	1.00
2.00	91.00	EMERGENCY	1,421,929	502,542	919,387	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	21,558	21,558	0	0	0	3.00
4.00	90.00	CLINIC	342,042	342,042	0	0	0	4.00
5.00	90.00	CLINIC	31,550	31,550	0	0	0	5.00
6.00	90.03	SURGICAL CLINIC	1,277,426	1,277,426	0	0	0	6.00
7.00	50.00	OPERATING ROOM	14,100	14,100	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			3,146,121	2,189,218	956,903		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	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	90.03	SURGICAL CLINIC	0	0	0	0	0	6.00
7.00	50.00	OPERATING ROOM	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	60.00	LABORATORY	0	0	0	0		1.00
2.00	91.00	EMERGENCY	0	0	0	502,542		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	21,558		3.00
4.00	90.00	CLINIC	0	0	0	342,042		4.00
5.00	90.00	CLINIC	0	0	0	31,550		5.00
6.00	90.03	SURGICAL CLINIC	0	0	0	1,277,426		6.00
7.00	50.00	OPERATING ROOM	0	0	0	14,100		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,189,218		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B Part I Date/Time Prepared: 10/10/2016 4:39 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,034,049	3,034,049				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,082,122		1,082,122			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,956,610	14,461	2,824	3,973,895		4.00
5.01	00550	DATA PROCESSING	638,186	60,163	74,681	114,292	887,322	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	119,340	64,900	0	38,247	6,127	5.02
5.03	00570	ADMITTING	206,593	25,925	0	49,444	30,803	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	545,021	24,161	225	96,442	0	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GENERAL	2,215,707	68,704	9,314	122,657	110,617	5.05
7.00	00700	OPERATION OF PLANT	1,062,982	179,080	22,832	65,622	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	127,550	19,299	1,467	9,823	0	8.00
9.00	00900	HOUSEKEEPING	464,031	33,634	0	116,426	2,553	9.00
10.00	01000	DIETARY	660,829	76,514	8,680	145,410	15,827	10.00
11.00	01100	CAFETERIA	0	49,834	0	0	2,723	11.00
13.00	01300	NURSING ADMINISTRATION	382,323	21,163	451	100,073	14,806	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	64,759	2,671	0	0	0	14.00
15.00	01500	PHARMACY	422,739	30,989	3,107	66,038	27,910	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	403,549	34,995	4,996	111,337	55,309	16.00
17.00	01700	SOCIAL SERVICE	125,572	8,490	0	40,742	5,446	17.00
18.00	01080	INSERVICE EDUCATION	135,468	23,330	3,964	31,224	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,077,133	287,036	95,135	615,764	174,433	30.00
43.00	04300	NURSERY	100,420	5,795	6,386	30,353	0	43.00
44.00	04400	SKILLED NURSING FACILITY	924,436	369,597	43,983	281,436	27,910	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,436,248	302,934	214,180	390,856	135,294	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	63,727	2,595	0	20,827	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,028,710	187,520	386,948	245,988	25,357	54.00
60.00	06000	LABORATORY	1,468,980	59,005	62,309	206,898	24,846	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	110,573	1,940	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	3,182	4,283	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,123,543	192,962	27,353	348,098	39,992	66.00
67.00	06700	OCCUPATIONAL THERAPY	414,062	75,834	0	126,926	5,105	67.00
68.00	06800	SPEECH PATHOLOGY	92,303	12,521	0	28,099	3,404	68.00
69.00	06900	ELECTROCARDIOLOGY	412,651	26,051	15,919	76,061	10,041	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,492,226	5,291	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	972,534	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	130,190	15,948	0	21,557	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	495,209	0	32,982	88,163	94,961	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	612,339	0	28,277	12,804	0	90.03
91.00	09100	EMERGENCY	1,594,878	150,787	24,634	175,129	46,289	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	572,043	25,396	267	153,511	27,569	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,772,817	2,463,808	1,070,914	3,930,247	887,322	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,781	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	110,738	0	4,698	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	2,522	0	0	0	0	192.02
192.03	19202	LEASED SPACE	93,872	132,395	6,279	6,268	0	192.03
194.00	07955	FOUNDATION	0	8,465	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	145,176	0	231	37,380	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	12,244	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B Part I Date/Time Prepared: 10/10/2016 4:39 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	403,356	0	0	0	194.06
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)	33,125,125	3,034,049	1,082,122	3,973,895	887,322	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B Part I Date/Time Prepared: 10/10/2016 4:39 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	ALL OTHER ADMINISTRATIVE AND GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	228,614					5.02
5.03	00570	ADMITTING	181	312,946				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	452	0	666,301			5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GENERAL	1,067	0	0	2,528,066	2,528,066	5.05
7.00	00700	OPERATION OF PLANT	3,268	0	0	1,333,784	111,675	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	144	0	0	158,283	13,253	8.00
9.00	00900	HOUSEKEEPING	3,972	0	0	620,616	51,963	9.00
10.00	01000	DIETARY	1,878	0	0	909,138	76,120	10.00
11.00	01100	CAFETERIA	0	0	0	52,557	4,400	11.00
13.00	01300	NURSING ADMINISTRATION	288	0	0	519,104	43,464	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,056	0	0	69,486	5,818	14.00
15.00	01500	PHARMACY	437	0	0	551,220	46,153	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	198	0	0	610,384	51,106	16.00
17.00	01700	SOCIAL SERVICE	11	0	0	180,261	15,093	17.00
18.00	01080	INSERVICE EDUCATION	391	0	0	194,377	16,275	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,296	15,291	31,001	3,305,089	276,728	30.00
43.00	04300	NURSERY	445	1,711	3,468	148,578	12,440	43.00
44.00	04400	SKILLED NURSING FACILITY	1,742	0	19,442	1,668,546	139,704	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	62,495	65,822	119,755	3,727,584	312,110	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,320	4,704	94,173	7,885	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,361	60,505	122,639	3,071,028	257,131	54.00
60.00	06000	LABORATORY	24,496	34,804	70,560	1,951,898	163,429	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	971	1,969	115,453	9,667	62.00
64.00	06400	INTRAVENOUS THERAPY	188	14,925	30,259	52,837	4,424	64.00
66.00	06600	PHYSICAL THERAPY	841	19,457	39,447	1,791,693	150,015	66.00
67.00	06700	OCCUPATIONAL THERAPY	390	6,744	13,673	642,734	53,815	67.00
68.00	06800	SPEECH PATHOLOGY	60	1,009	2,046	139,442	11,675	68.00
69.00	06900	ELECTROCARDIOLOGY	1,211	12,952	25,677	580,563	48,609	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,714	3,475	5,189	434	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	87,980	13,854	28,088	1,627,439	136,262	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,635	41,835	1,035,004	86,659	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	312	3,869	7,844	179,720	15,048	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	1,824	0	4,909	718,048	60,121	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	173	0	14,338	667,931	55,925	90.03
91.00	09100	EMERGENCY	6,621	29,600	36,765	2,064,703	172,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,781	0	6,870	787,437	65,931	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	227,559	306,183	628,764	32,102,365	2,476,205	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	13,781	1,154	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	435	0	0	115,871	9,702	192.01
192.02	19201	CARDIOLOGY CLINIC	4	0	0	2,526	211	192.02
192.03	19202	LEASED SPACE	60	0	0	238,874	20,000	192.03
194.00	07955	FOUNDATION	0	0	0	8,465	709	194.00
194.01	07950	SPORTS MEDICINE	556	0	23,826	207,169	17,346	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	12,244	1,025	194.02
194.03	07952	ANESTHESIA BILLNG	0	6,763	13,711	20,474	1,714	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	403,356	0	194.06
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)	228,614	312,946	666,301	33,125,125	2,528,066	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B Part I | Date/Time Prepared: 10/10/2016 4:39 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	1,445,459					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,222	184,758				8.00
9.00	00900	HOUSEKEEPING	23,044	17,671	713,294			9.00
10.00	01000	DIETARY	52,423	1,187	43,634	1,082,502		10.00
11.00	01100	CAFETERIA	34,143	0	8,168	745,543	844,811	11.00
13.00	01300	NURSING ADMINISTRATION	14,500	0	0	0	19,939	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,830	0	0	0	0	14.00
15.00	01500	PHARMACY	21,232	0	2,402	0	14,681	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,976	0	6,552	0	51,903	16.00
17.00	01700	SOCIAL SERVICE	5,817	0	1,616	0	12,078	17.00
18.00	01080	INSERVICE EDUCATION	15,984	0	0	0	7,757	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	196,660	40,769	180,780	80,492	163,046	30.00
43.00	04300	NURSERY	3,970	0	4,149	0	7,080	43.00
44.00	04400	SKILLED NURSING FACILITY	253,226	54,971	172,918	256,467	122,442	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	207,552	22,809	121,030	0	109,532	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,778	0	0	0	4,841	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	128,477	15,489	29,002	0	65,126	54.00
60.00	06000	LABORATORY	40,426	0	15,724	0	71,893	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,329	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	2,934	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	132,206	11,274	23,586	0	88,188	66.00
67.00	06700	OCCUPATIONAL THERAPY	51,957	0	3,756	0	28,945	67.00
68.00	06800	SPEECH PATHOLOGY	8,579	0	0	0	6,195	68.00
69.00	06900	ELECTROCARDIOLOGY	17,848	0	5,678	0	20,355	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,625	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	10,927	1,643	0	0	6,351	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	103,310	18,945	35,684	0	42,116	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	17,400	0	3,145	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,388,375	184,758	657,824	1,082,502	842,468	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,442	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	39,253	0	55,470	0	2,343	192.03
194.00	07955	FOUNDATION	0	0	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	8,389	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
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)	1,445,459	184,758	713,294	1,082,502	844,811	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B Part I Date/Time Prepared: 10/10/2016 4:39 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	597,007					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	77,134				14.00
15.00	01500	PHARMACY	20,240	0	655,928			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	743,921		16.00
17.00	01700	SOCIAL SERVICE	16,651	0	0	0	231,516	17.00
18.00	01080	INSERVICE EDUCATION	10,694	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	224,794	0	0	35,510	118,493	30.00
43.00	04300	NURSERY	9,761	0	0	3,973	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	10,782	98,704	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	151,010	0	0	137,174	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,675	0	0	5,388	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	140,535	0	54.00
60.00	06000	LABORATORY	99,118	0	0	80,824	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,256	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	34,660	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	45,185	80	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	15,661	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,344	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	29,412	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	77,134	0	3,981	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	32,174	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	655,928	47,921	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	8,985	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	5,623	1,609	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	16,423	0	90.03
91.00	09100	EMERGENCY	58,064	0	0	42,113	7,803	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	4,827	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	597,007	77,134	655,928	700,924	231,516	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
194.00	07955	FOUNDATION	0	0	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	27,292	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	15,705	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
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)	597,007	77,134	655,928	743,921	231,516	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B Part I | Date/Time Prepared: 10/10/2016 4:39 pm

		Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			18.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
18.00	01080	INSERVICE EDUCATION	245,087					18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,800	4,634,161	0	4,634,161		30.00
43.00	04300	NURSERY	1,320	191,271	0	191,271		43.00
44.00	04400	SKILLED NURSING FACILITY	3,583	2,781,343	0	2,781,343		44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,805	4,839,606	0	4,839,606		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,790	122,530	0	122,530		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,690	3,753,478	0	3,753,478		54.00
60.00	06000	LABORATORY	26,857	2,450,169	0	2,450,169		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	750	129,455	0	129,455		62.00
64.00	06400	INTRAVENOUS THERAPY	11,517	106,372	0	106,372		64.00
66.00	06600	PHYSICAL THERAPY	15,014	2,257,241	0	2,257,241		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,204	802,072	0	802,072		67.00
68.00	06800	SPEECH PATHOLOGY	779	169,014	0	169,014		68.00
69.00	06900	ELECTROCARDIOLOGY	9,995	712,460	0	712,460		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,323	88,061	0	88,061		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,691	1,810,191	0	1,810,191		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,923	1,841,435	0	1,841,435		73.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	2,986	225,660	0	225,660		76.01
76.02	03950	IV THERAPY	0	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
90.00	09000	CLINIC	0	785,401	0	785,401		90.00
90.01	09001	OB CLINIC	0	0	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0		90.02
90.03	09003	SURGICAL CLINIC	0	740,279	0	740,279		90.03
91.00	09100	EMERGENCY	22,841	2,568,452	0	2,568,452		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	878,740	0	878,740		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	239,868	31,887,391	0	31,887,391		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,377	0	24,377		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19203	MUSCATINE CLINIC	0	125,573	0	125,573		192.01
192.02	19201	CARDIOLOGY CLINIC	0	2,737	0	2,737		192.02
192.03	19202	LEASED SPACE	0	355,940	0	355,940		192.03
194.00	07955	FOUNDATION	0	9,174	0	9,174		194.00
194.01	07950	SPORTS MEDICINE	0	251,807	0	251,807		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	21,658	0	21,658		194.02
194.03	07952	ANESTHESIA BILLNG	5,219	43,112	0	43,112		194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0		194.04
194.05	07954	COLONA CLINIC	0	0	0	0		194.05

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B Part I Date/Time Prepared: 10/10/2016 4:39 pm

		Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			18.00	24.00	25.00	26.00		
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	403,356	0	403,356		194.06
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	245,087	33,125,125	0	33,125,125		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B Part II | Date/Time Prepared: 10/10/2016 4:39 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	14,461	2,824	17,285	17,285	4.00
5.01	00550	DATA PROCESSING	0	60,163	74,681	134,844	497	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	64,900	0	64,900	166	5.02
5.03	00570	ADMITTING	0	25,925	0	25,925	215	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	24,161	225	24,386	420	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GENERAL	0	68,704	9,314	78,018	534	5.05
7.00	00700	OPERATION OF PLANT	0	179,080	22,832	201,912	286	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,299	1,467	20,766	43	8.00
9.00	00900	HOUSEKEEPING	0	33,634	0	33,634	507	9.00
10.00	01000	DIETARY	0	76,514	8,680	85,194	633	10.00
11.00	01100	CAFETERIA	0	49,834	0	49,834	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	21,163	451	21,614	435	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,671	0	2,671	0	14.00
15.00	01500	PHARMACY	0	30,989	3,107	34,096	287	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34,995	4,996	39,991	484	16.00
17.00	01700	SOCIAL SERVICE	0	8,490	0	8,490	177	17.00
18.00	01080	INSERVICE EDUCATION	0	23,330	3,964	27,294	136	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	287,036	95,135	382,171	2,672	30.00
43.00	04300	NURSERY	0	5,795	6,386	12,181	132	43.00
44.00	04400	SKILLED NURSING FACILITY	0	369,597	43,983	413,580	1,225	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	302,934	214,180	517,114	1,701	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,595	0	2,595	91	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	187,520	386,948	574,468	1,070	54.00
60.00	06000	LABORATORY	0	59,005	62,309	121,314	900	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,940	0	1,940	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	4,283	0	4,283	0	64.00
66.00	06600	PHYSICAL THERAPY	0	192,962	27,353	220,315	1,515	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	75,834	0	75,834	552	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,521	0	12,521	122	68.00
69.00	06900	ELECTROCARDIOLOGY	0	26,051	15,919	41,970	331	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,291	0	5,291	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	15,948	0	15,948	94	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	32,982	32,982	384	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	28,277	28,277	56	90.03
91.00	09100	EMERGENCY	0	150,787	24,634	175,421	762	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	25,396	267	25,663	668	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,463,808	1,070,914	3,534,722	17,095	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,781	0	13,781	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	4,698	4,698	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	132,395	6,279	138,674	27	192.03
194.00	07955	FOUNDATION	0	8,465	0	8,465	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	231	231	163	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	12,244	0	12,244	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	403,356	0	403,356	0	194.06

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B Part II Date/Time Prepared: 10/10/2016 4:39 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	3,034,049	1,082,122	4,116,171	17,285	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B Part II | Date/Time Prepared: 10/10/2016 4:39 pm

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	ALL OTHER ADMINISTRATIVE AND GENERAL	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING	135,341					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	934	66,000				5.02
5.03	00570	ADMITTING	4,698	52	30,890			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	131	0	24,937		5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GENERAL	16,872	308	0	0	95,732	5.05
7.00	00700	OPERATION OF PLANT	0	943	0	0	4,229	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	42	0	0	502	8.00
9.00	00900	HOUSEKEEPING	389	1,147	0	0	1,968	9.00
10.00	01000	DIETARY	2,414	542	0	0	2,883	10.00
11.00	01100	CAFETERIA	415	0	0	0	167	11.00
13.00	01300	NURSING ADMINISTRATION	2,258	83	0	0	1,646	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	594	0	0	220	14.00
15.00	01500	PHARMACY	4,257	126	0	0	1,748	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,436	57	0	0	1,936	16.00
17.00	01700	SOCIAL SERVICE	831	3	0	0	572	17.00
18.00	01080	INSERVICE EDUCATION	0	113	0	0	616	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,608	2,684	1,510	1,160	10,480	30.00
43.00	04300	NURSERY	0	128	169	130	471	43.00
44.00	04400	SKILLED NURSING FACILITY	4,257	503	0	727	5,291	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,636	18,042	6,492	4,481	11,809	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	229	176	299	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,868	3,857	5,973	4,593	9,738	54.00
60.00	06000	LABORATORY	3,790	7,072	3,436	2,640	6,189	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	96	74	366	62.00
64.00	06400	INTRAVENOUS THERAPY	0	54	1,473	1,132	168	64.00
66.00	06600	PHYSICAL THERAPY	6,100	243	1,921	1,476	5,681	66.00
67.00	06700	OCCUPATIONAL THERAPY	779	113	666	512	2,038	67.00
68.00	06800	SPEECH PATHOLOGY	519	17	100	77	442	68.00
69.00	06900	ELECTROCARDIOLOGY	1,531	350	1,279	961	1,841	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	169	130	16	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,399	1,368	1,051	5,161	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,037	1,565	3,282	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	90	382	294	570	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	14,484	527	0	184	2,277	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	50	0	536	2,118	90.03
91.00	09100	EMERGENCY	7,060	1,911	2,922	1,376	6,547	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	4,205	514	0	257	2,497	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	135,341	65,695	30,222	23,532	93,768	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	44	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	126	0	0	367	192.01
192.02	19201	CARDIOLOGY CLINIC	0	1	0	0	8	192.02
192.03	19202	LEASED SPACE	0	17	0	0	757	192.03
194.00	07955	FOUNDATION	0	0	0	0	27	194.00
194.01	07950	SPORTS MEDICINE	0	161	0	892	657	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	39	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	668	513	65	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
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)	135,341	66,000	30,890	24,937	95,732	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B Part II | Date/Time Prepared: 10/10/2016 4:39 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	207,370					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,897	23,250				8.00
9.00	00900	HOUSEKEEPING	3,306	2,224	43,175			9.00
10.00	01000	DIETARY	7,521	149	2,641	101,977		10.00
11.00	01100	CAFETERIA	4,898	0	494	70,234	126,042	11.00
13.00	01300	NURSING ADMINISTRATION	2,080	0	0	0	2,975	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	262	0	0	0	0	14.00
15.00	01500	PHARMACY	3,046	0	145	0	2,190	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,440	0	397	0	7,744	16.00
17.00	01700	SOCIAL SERVICE	835	0	98	0	1,802	17.00
18.00	01080	INSERVICE EDUCATION	2,293	0	0	0	1,157	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,213	5,130	10,942	7,583	24,327	30.00
43.00	04300	NURSERY	570	0	251	0	1,056	43.00
44.00	04400	SKILLED NURSING FACILITY	36,326	6,918	10,467	24,160	18,268	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,776	2,870	7,326	0	16,342	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	255	0	0	0	722	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,432	1,949	1,755	0	9,716	54.00
60.00	06000	LABORATORY	5,800	0	952	0	10,726	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	191	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	421	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	18,967	1,419	1,428	0	13,157	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,454	0	227	0	4,318	67.00
68.00	06800	SPEECH PATHOLOGY	1,231	0	0	0	924	68.00
69.00	06900	ELECTROCARDIOLOGY	2,561	0	344	0	3,037	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	520	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,568	207	0	0	948	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	14,821	2,384	2,160	0	6,283	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	2,496	0	190	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	199,180	23,250	39,817	101,977	125,692	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,355	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	5,631	0	3,358	0	350	192.03
194.00	07955	FOUNDATION	0	0	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	1,204	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
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)	207,370	23,250	43,175	101,977	126,042	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B Part II | Date/Time Prepared: 10/10/2016 4:39 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	31,091					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,747				14.00
15.00	01500	PHARMACY	1,054	0	46,949			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	62,485		16.00
17.00	01700	SOCIAL SERVICE	867	0	0	0	13,675	17.00
18.00	01080	INSERVICE EDUCATION	557	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,707	0	0	2,984	6,999	30.00
43.00	04300	NURSERY	508	0	0	334	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	906	5,830	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,864	0	0	11,529	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	348	0	0	453	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,772	0	54.00
60.00	06000	LABORATORY	5,162	0	0	6,793	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	190	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,913	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,798	5	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,316	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	197	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,472	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,747	0	335	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,704	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	46,949	4,028	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	755	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	473	95	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	1,380	0	90.03
91.00	09100	EMERGENCY	3,024	0	0	3,539	461	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	285	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,091	3,747	46,949	58,871	13,675	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
194.00	07955	FOUNDATION	0	0	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	2,294	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	1,320	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
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)	31,091	3,747	46,949	62,485	13,675	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B Part II | Date/Time Prepared: 10/10/2016 4:39 pm

		Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			18.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
18.00	01080	INSERVICE EDUCATION	32,166					18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,548	526,718	0	526,718		30.00
43.00	04300	NURSERY	173	16,103	0	16,103		43.00
44.00	04400	SKILLED NURSING FACILITY	470	528,928	0	528,928		44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,679	662,661	0	662,661		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	235	5,403	0	5,403		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,125	653,316	0	653,316		54.00
60.00	06000	LABORATORY	3,523	178,297	0	178,297		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	98	2,955	0	2,955		62.00
64.00	06400	INTRAVENOUS THERAPY	1,511	11,955	0	11,955		64.00
66.00	06600	PHYSICAL THERAPY	1,970	277,995	0	277,995		66.00
67.00	06700	OCCUPATIONAL THERAPY	683	94,492	0	94,492		67.00
68.00	06800	SPEECH PATHOLOGY	102	16,252	0	16,252		68.00
69.00	06900	ELECTROCARDIOLOGY	1,311	57,988	0	57,988		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	174	4,571	0	4,571		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,402	42,896	0	42,896		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,089	59,950	0	59,950		73.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	392	21,248	0	21,248		76.01
76.02	03950	IV THERAPY	0	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
90.00	09000	CLINIC	0	51,406	0	51,406		90.00
90.01	09001	OB CLINIC	0	0	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0		90.02
90.03	09003	SURGICAL CLINIC	0	32,417	0	32,417		90.03
91.00	09100	EMERGENCY	2,996	231,667	0	231,667		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	36,775	0	36,775		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,481	3,513,993	0	3,513,993		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,180	0	15,180		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19203	MUSCATINE CLINIC	0	5,191	0	5,191		192.01
192.02	19201	CARDIOLOGY CLINIC	0	9	0	9		192.02
192.03	19202	LEASED SPACE	0	148,814	0	148,814		192.03
194.00	07955	FOUNDATION	0	8,492	0	8,492		194.00
194.01	07950	SPORTS MEDICINE	0	4,398	0	4,398		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	13,487	0	13,487		194.02
194.03	07952	ANESTHESIA BILLNG	685	3,251	0	3,251		194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0		194.04
194.05	07954	COLONA CLINIC	0	0	0	0		194.05

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B Part II Date/Time Prepared: 10/10/2016 4:39 pm

		Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			18.00	24.00	25.00	26.00		
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	403,356	0	403,356		194.06
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	32,166	4,116,171	0	4,116,171		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B-1 | Date/Time Prepared: 10/10/2016 4:39 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COST)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	120,427					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,001,110				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	574	2,613	12,159,445			4.00
5.01	00550	DATA PROCESSING	2,388	69,090	349,715	130,350		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	2,576	0	117,029	900	3,877,528	5.02
5.03	00570	ADMITTING	1,029	0	151,292	4,525	3,067	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	959	208	295,098	0	7,672	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GENERAL	2,727	8,617	375,310	16,250	18,099	5.05
7.00	00700	OPERATION OF PLANT	7,108	21,123	200,792	0	55,424	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	766	1,357	30,057	0	2,446	8.00
9.00	00900	HOUSEKEEPING	1,335	0	356,244	375	67,374	9.00
10.00	01000	DIETARY	3,037	8,030	444,931	2,325	31,855	10.00
11.00	01100	CAFETERIA	1,978	0	0	400	0	11.00
13.00	01300	NURSING ADMINISTRATION	840	417	306,206	2,175	4,879	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	106	0	0	0	34,876	14.00
15.00	01500	PHARMACY	1,230	2,874	202,064	4,100	7,414	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,389	4,622	340,672	8,125	3,353	16.00
17.00	01700	SOCIAL SERVICE	337	0	124,664	800	189	17.00
18.00	01080	INSERVICE EDUCATION	926	3,667	95,540	0	6,636	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,393	88,013	1,884,117	25,625	157,669	30.00
43.00	04300	NURSERY	230	5,908	92,874	0	7,546	43.00
44.00	04400	SKILLED NURSING FACILITY	14,670	40,690	861,149	4,100	29,540	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,024	198,146	1,195,954	19,875	1,059,971	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	103	0	63,727	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,443	357,980	752,683	3,725	226,619	54.00
60.00	06000	LABORATORY	2,342	57,644	633,075	3,650	415,477	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	77	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	170	0	0	0	3,182	64.00
66.00	06600	PHYSICAL THERAPY	7,659	25,305	1,065,122	5,875	14,266	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,010	0	388,373	750	6,622	67.00
68.00	06800	SPEECH PATHOLOGY	497	0	85,979	500	1,019	68.00
69.00	06900	ELECTROCARDIOLOGY	1,034	14,727	232,734	1,475	20,535	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	210	0	0	0	1,492,226	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	633	0	65,961	0	5,300	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	30,513	269,763	13,950	30,935	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	26,160	39,177	0	2,942	90.03
91.00	09100	EMERGENCY	5,985	22,790	535,867	6,800	112,295	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,008	247	469,719	4,050	30,201	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	97,793	990,741	12,025,888	130,350	3,859,629	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	547	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	4,346	0	0	7,377	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	75	192.02
192.03	19202	LEASED SPACE	5,255	5,809	19,180	0	1,017	192.03
194.00	07955	FOUNDATION	336	0	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	0	214	114,377	0	9,430	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	486	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B-1 | Date/Time Prepared: 10/10/2016 4:39 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COST)	
			1.00	2.00	4.00	5.01	5.02	
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	16,010	0	0	0	0	194.06
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)	3,034,049	1,082,122	3,973,895	887,322	228,614	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.194093	1.080922	0.326815	6.807227	0.058959	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			17,285	135,341	66,000	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001422	1.038289	0.017021	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B-1 | Date/Time Prepared: 10/10/2016 4:39 pm

		Cost Center Description	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	ALL OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING	78,612,396					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	82,558,386				5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GENERAL	0	0	-2,528,066	30,193,703		5.05
7.00	00700	OPERATION OF PLANT	0	0	0	1,333,784	83,739	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	158,283	766	8.00
9.00	00900	HOUSEKEEPING	0	0	0	620,616	1,335	9.00
10.00	01000	DIETARY	0	0	0	909,138	3,037	10.00
11.00	01100	CAFETERIA	0	0	0	52,557	1,978	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	519,104	840	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	69,486	106	14.00
15.00	01500	PHARMACY	0	0	0	551,220	1,230	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	610,384	1,389	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	180,261	337	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	194,377	926	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,841,012	3,841,012	0	3,305,089	11,393	30.00
43.00	04300	NURSERY	429,738	429,738	0	148,578	230	43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,408,907	0	1,668,546	14,670	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,536,409	14,837,657	0	3,727,584	12,024	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	582,804	582,804	0	94,173	103	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,198,491	15,198,467	0	3,071,028	7,443	54.00
60.00	06000	LABORATORY	8,742,424	8,742,424	0	1,951,898	2,342	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	243,981	243,981	0	115,453	77	62.00
64.00	06400	INTRAVENOUS THERAPY	3,749,056	3,749,056	0	52,837	170	64.00
66.00	06600	PHYSICAL THERAPY	4,887,458	4,887,458	0	1,791,693	7,659	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,694,035	1,694,035	0	642,734	3,010	67.00
68.00	06800	SPEECH PATHOLOGY	253,561	253,561	0	139,442	497	68.00
69.00	06900	ELECTROCARDIOLOGY	3,253,443	3,181,401	0	580,563	1,034	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	430,609	430,609	0	5,189	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,480,116	3,480,116	0	1,627,439	210	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,183,428	5,183,428	0	1,035,004	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	971,860	971,860	0	179,720	633	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	608,213	0	718,048	0	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	1,776,437	0	667,931	0	90.03
91.00	09100	EMERGENCY	7,435,219	4,555,228	0	2,064,703	5,985	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	851,209	0	787,437	1,008	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	76,913,644	77,907,601	-2,528,066	29,574,299	80,432	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	13,781	547	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	115,871	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	2,526	0	192.02
192.03	19202	LEASED SPACE	0	0	0	238,874	2,274	192.03
194.00	07955	FOUNDATION	0	0	0	8,465	0	194.00
194.01	07950	SPORTS MEDICINE	0	2,952,033	0	207,169	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	12,244	486	194.02
194.03	07952	ANESTHESIA BILLNG	1,698,752	1,698,752	0	20,474	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	-403,356	0	0	194.06
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B-1 | Date/Time Prepared: 10/10/2016 4:39 pm

	Cost Center Description	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	ALL OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	7.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	312,946	666,301		2,528,066	1,445,459	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.003981	0.008071		0.083728	17.261479	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	30,890	24,937		95,732	207,370	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000393	0.000302		0.003171	2.476385	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B-1 | Date/Time Prepared: 10/10/2016 4:39 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	240,361					8.00
9.00	00900	HOUSEKEEPING	22,989	489,930				9.00
10.00	01000	DIETARY	1,544	29,970	144,639			10.00
11.00	01100	CAFETERIA	0	5,610	99,616	16,228		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	383	8,318	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	1,650	0	282	282	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,500	0	997	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,110	0	232	232	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	149	149	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	53,039	124,170	10,755	3,132	3,132	30.00
43.00	04300	NURSERY	0	2,850	0	136	136	43.00
44.00	04400	SKILLED NURSING FACILITY	71,514	118,770	34,268	2,352	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,674	83,130	0	2,104	2,104	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	93	93	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,150	19,920	0	1,251	0	54.00
60.00	06000	LABORATORY	0	10,800	0	1,381	1,381	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	14,667	16,200	0	1,694	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,580	0	556	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	119	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,900	0	391	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,137	0	0	122	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	24,647	24,510	0	809	809	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	2,160	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	240,361	451,830	144,639	16,183	8,318	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	38,100	0	45	0	192.03
194.00	07955	FOUNDATION	0	0	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B-1 | Date/Time Prepared: 10/10/2016 4:39 pm

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	
		8.00	9.00	10.00	11.00	13.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	184,758	713,294	1,082,502	844,811	597,007	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.768669	1.455910	7.484164	52.058849	71.772902	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	23,250	43,175	101,977	126,042	31,091	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.096730	0.088125	0.705045	7.766946	3.737798	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B-1 | Date/Time Prepared: 10/10/2016 4:39 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE INSERVICE EDUCATION (GROSS CHAR GES)	
			14.00	15.00	16.00	17.00	18.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100					14.00
15.00	01500	PHARMACY	0	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	80,464,526			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	71,950		17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	0	79,778,652	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	3,841,012	36,825	3,841,012	30.00
43.00	04300	NURSERY	0	0	429,738	0	429,738	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	1,166,256	30,675	1,166,256	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	14,837,657	0	16,536,409	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	582,804	0	582,804	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	15,198,467	0	15,198,491	54.00
60.00	06000	LABORATORY	0	0	8,742,424	0	8,742,424	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	243,981	0	243,981	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	3,749,056	0	3,749,056	64.00
66.00	06600	PHYSICAL THERAPY	0	0	4,887,458	25	4,887,458	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,694,035	0	1,694,035	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	253,561	0	253,561	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	3,181,401	0	3,253,443	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	100	0	430,609	0	430,609	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,480,116	0	3,480,116	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	5,183,428	0	5,183,428	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	971,860	0	971,860	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	608,213	500	0	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	1,776,437	0	0	90.03
91.00	09100	EMERGENCY	0	0	4,555,228	2,425	7,435,219	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,500	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	100	75,813,741	71,950	78,079,900	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
194.00	07955	FOUNDATION	0	0	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	2,952,033	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	1,698,752	0	1,698,752	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet B-1 | Date/Time Prepared: 10/10/2016 4:39 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE INSERVICE EDUCATION (GROSS CHAR GES)	
			14.00	15.00	16.00	17.00	18.00	
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
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)	77,134	655,928	743,921	231,516	245,087	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	771.340000	6,559.280000	0.009245	3.217735	0.003072	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,747	46,949	62,485	13,675	32,166	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	37.470000	469.490000	0.000777	0.190063	0.000403	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet C Part I Date/Time Prepared: 10/10/2016 4:39 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	4,634,161		4,634,161	0	4,634,161	30.00
43.00	04300	NURSERY	191,271		191,271	0	191,271	43.00
44.00	04400	SKILLED NURSING FACILITY	2,781,343		2,781,343	0	2,781,343	44.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,839,606		4,839,606	0	4,839,606	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	122,530		122,530	0	122,530	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,753,478		3,753,478	0	3,753,478	54.00
60.00	06000	LABORATORY	2,450,169		2,450,169	0	2,450,169	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	129,455		129,455	0	129,455	62.00
64.00	06400	INTRAVENOUS THERAPY	106,372		106,372	0	106,372	64.00
66.00	06600	PHYSICAL THERAPY	2,257,241	0	2,257,241	0	2,257,241	66.00
67.00	06700	OCCUPATIONAL THERAPY	802,072	0	802,072	0	802,072	67.00
68.00	06800	SPEECH PATHOLOGY	169,014	0	169,014	0	169,014	68.00
69.00	06900	ELECTROCARDIOLOGY	712,460		712,460	0	712,460	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	88,061		88,061	0	88,061	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,810,191		1,810,191	0	1,810,191	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,841,435		1,841,435	0	1,841,435	73.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	225,660		225,660	0	225,660	76.01
76.02	03950	IV THERAPY	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	785,401		785,401	0	785,401	90.00
90.01	09001	OB CLINIC	0		0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0		0	0	0	90.02
90.03	09003	SURGICAL CLINIC	740,279		740,279	0	740,279	90.03
91.00	09100	EMERGENCY	2,568,452		2,568,452	0	2,568,452	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	529,992		529,992		529,992	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	878,740		878,740		878,740	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	32,417,383	0	32,417,383	0	32,417,383	200.00
201.00		Less Observation Beds	529,992		529,992		529,992	201.00
202.00		Total (see instructions)	31,887,391	0	31,887,391	0	31,887,391	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet C Part I Date/Time Prepared: 10/10/2016 4:39 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	3,348,767		3,348,767			30.00
43.00	04300	NURSERY	429,738		429,738			43.00
44.00	04400	SKILLED NURSING FACILITY	2,408,907		2,408,907			44.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,551,371	9,286,286	14,837,657	0.326170	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	475,335	107,469	582,804	0.210242	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	810,203	14,388,264	15,198,467	0.246964	0.000000	54.00
60.00	06000	LABORATORY	1,187,573	7,554,851	8,742,424	0.280262	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	143,735	100,246	243,981	0.530595	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	3,022,186	726,870	3,749,056	0.028373	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	731,721	4,155,737	4,887,458	0.461844	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	465,851	1,228,184	1,694,035	0.473468	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	75,185	178,376	253,561	0.666561	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	176,005	3,005,396	3,181,401	0.223945	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	355,256	75,353	430,609	0.204503	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,962,604	517,512	3,480,116	0.520152	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,602,588	2,580,840	5,183,428	0.355254	0.000000	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	971,860	971,860	0.232194	0.000000	76.01
76.02	03950	IV THERAPY	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
90.00	09000	CLINIC	0	608,213	608,213	1.291326	0.000000	90.00
90.01	09001	OB CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	SURGICAL CLINIC	670,569	1,105,868	1,776,437	0.416721	0.000000	90.03
91.00	09100	EMERGENCY	170,853	4,384,375	4,555,228	0.563847	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	32,797	459,448	492,245	1.076683	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	851,209	851,209			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,621,244	52,286,357	77,907,601			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	25,621,244	52,286,357	77,907,601			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet C Part I Date/Time Prepared: 10/10/2016 4:39 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
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.02	03950	IV THERAPY	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OB CLINIC	0.000000		90.01
90.02	09002	SPECIALTY CLINIC	0.000000		90.02
90.03	09003	SURGICAL CLINIC	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
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: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet C Part I Date/Time Prepared: 10/10/2016 4:39 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	4,634,161		4,634,161	0	4,634,161	30.00
43.00	04300	NURSERY	191,271		191,271	0	191,271	43.00
44.00	04400	SKILLED NURSING FACILITY	2,781,343		2,781,343	0	2,781,343	44.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,839,606		4,839,606	0	4,839,606	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	122,530		122,530	0	122,530	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,753,478		3,753,478	0	3,753,478	54.00
60.00	06000	LABORATORY	2,450,169		2,450,169	0	2,450,169	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	129,455		129,455	0	129,455	62.00
64.00	06400	INTRAVENOUS THERAPY	106,372		106,372	0	106,372	64.00
66.00	06600	PHYSICAL THERAPY	2,257,241	0	2,257,241	0	2,257,241	66.00
67.00	06700	OCCUPATIONAL THERAPY	802,072	0	802,072	0	802,072	67.00
68.00	06800	SPEECH PATHOLOGY	169,014	0	169,014	0	169,014	68.00
69.00	06900	ELECTROCARDIOLOGY	712,460		712,460	0	712,460	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	88,061		88,061	0	88,061	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,810,191		1,810,191	0	1,810,191	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,841,435		1,841,435	0	1,841,435	73.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	225,660		225,660	0	225,660	76.01
76.02	03950	IV THERAPY	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	785,401		785,401	0	785,401	90.00
90.01	09001	OB CLINIC	0		0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0		0	0	0	90.02
90.03	09003	SURGICAL CLINIC	740,279		740,279	0	740,279	90.03
91.00	09100	EMERGENCY	2,568,452		2,568,452	0	2,568,452	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	529,992		529,992		529,992	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	878,740		878,740		878,740	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	32,417,383	0	32,417,383	0	32,417,383	200.00
201.00		Less Observation Beds	529,992		529,992		529,992	201.00
202.00		Total (see instructions)	31,887,391	0	31,887,391	0	31,887,391	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet C Part I Date/Time Prepared: 10/10/2016 4:39 pm

Title XIX | 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	3,348,767		3,348,767			30.00
43.00	04300	NURSERY	429,738		429,738			43.00
44.00	04400	SKILLED NURSING FACILITY	2,408,907		2,408,907			44.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,551,371	9,286,286	14,837,657	0.326170	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	475,335	107,469	582,804	0.210242	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	810,203	14,388,264	15,198,467	0.246964	0.000000	54.00
60.00	06000	LABORATORY	1,187,573	7,554,851	8,742,424	0.280262	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	143,735	100,246	243,981	0.530595	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	3,022,186	726,870	3,749,056	0.028373	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	731,721	4,155,737	4,887,458	0.461844	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	465,851	1,228,184	1,694,035	0.473468	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	75,185	178,376	253,561	0.666561	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	176,005	3,005,396	3,181,401	0.223945	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	355,256	75,353	430,609	0.204503	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,962,604	517,512	3,480,116	0.520152	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,602,588	2,580,840	5,183,428	0.355254	0.000000	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	971,860	971,860	0.232194	0.000000	76.01
76.02	03950	IV THERAPY	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
90.00	09000	CLINIC	0	608,213	608,213	1.291326	0.000000	90.00
90.01	09001	OB CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	SURGICAL CLINIC	670,569	1,105,868	1,776,437	0.416721	0.000000	90.03
91.00	09100	EMERGENCY	170,853	4,384,375	4,555,228	0.563847	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	32,797	459,448	492,245	1.076683	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	851,209	851,209			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,621,244	52,286,357	77,907,601			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	25,621,244	52,286,357	77,907,601			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet C Part I Date/Time Prepared: 10/10/2016 4:39 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
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.02	03950	IV THERAPY	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OB CLINIC	0.000000		90.01
90.02	09002	SPECIALTY CLINIC	0.000000		90.02
90.03	09003	SURGICAL CLINIC	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
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: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet D Part II Date/Time Prepared: 10/10/2016 4:39 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	662,661	14,837,657	0.044661	2,290,987	102,318	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,403	582,804	0.009271	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	653,316	15,198,467	0.042986	330,297	14,198	54.00
60.00	06000	LABORATORY	178,297	8,742,424	0.020394	417,508	8,515	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,955	243,981	0.012112	81,647	989	62.00
64.00	06400	INTRAVENOUS THERAPY	11,955	3,749,056	0.003189	1,309,920	4,177	64.00
66.00	06600	PHYSICAL THERAPY	277,995	4,887,458	0.056879	171,946	9,780	66.00
67.00	06700	OCCUPATIONAL THERAPY	94,492	1,694,035	0.055779	103,856	5,793	67.00
68.00	06800	SPEECH PATHOLOGY	16,252	253,561	0.064095	16,498	1,057	68.00
69.00	06900	ELECTROCARDIOLOGY	57,988	3,181,401	0.018227	99,593	1,815	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,571	430,609	0.010615	224,303	2,381	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,896	3,480,116	0.012326	1,426,303	17,581	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,950	5,183,428	0.011566	1,061,257	12,274	73.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	21,248	971,860	0.021863	0	0	76.01
76.02	03950	IV THERAPY	0	0	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	51,406	608,213	0.084520	0	0	90.00
90.01	09001	OB CLINIC	0	0	0.000000	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0.000000	0	0	90.02
90.03	09003	SURGICAL CLINIC	32,417	1,776,437	0.018248	0	0	90.03
91.00	09100	EMERGENCY	231,667	4,555,228	0.050857	2,321	118	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	60,239	492,245	0.122376	7,463	913	92.00
200.00		Total (lines 50-199)	2,465,708	70,868,980		7,543,899	181,909	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet D Part IV | Date/Time Prepared: 10/10/2016 4:39 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet D Part IV Date/Time Prepared: 10/10/2016 4:39 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	14,837,657	0.000000	0.000000	2,290,987	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	582,804	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,198,467	0.000000	0.000000	330,297	54.00
60.00	06000	LABORATORY	0	8,742,424	0.000000	0.000000	417,508	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	243,981	0.000000	0.000000	81,647	62.00
64.00	06400	INTRAVENOUS THERAPY	0	3,749,056	0.000000	0.000000	1,309,920	64.00
66.00	06600	PHYSICAL THERAPY	0	4,887,458	0.000000	0.000000	171,946	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,694,035	0.000000	0.000000	103,856	67.00
68.00	06800	SPEECH PATHOLOGY	0	253,561	0.000000	0.000000	16,498	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,181,401	0.000000	0.000000	99,593	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	430,609	0.000000	0.000000	224,303	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,480,116	0.000000	0.000000	1,426,303	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,183,428	0.000000	0.000000	1,061,257	73.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	971,860	0.000000	0.000000	0	76.01
76.02	03950	IV THERAPY	0	0	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	608,213	0.000000	0.000000	0	90.00
90.01	09001	OB CLINIC	0	0	0.000000	0.000000	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0.000000	0.000000	0	90.02
90.03	09003	SURGICAL CLINIC	0	1,776,437	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	4,555,228	0.000000	0.000000	2,321	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	492,245	0.000000	0.000000	7,463	92.00
200.00		Total (lines 50-199)	0	70,868,980			7,543,899	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet D Part IV | Date/Time Prepared: 10/10/2016 4:39 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.02	03950	IV THERAPY	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OB CLINIC	0	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0	0		90.02
90.03	09003	SURGICAL CLINIC	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet D Part V Date/Time Prepared: 10/10/2016 4:39 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	0.326170	0	2,405,486	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.210242	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246964	0	4,490,842	0	0	54.00
60.00	06000	LABORATORY	0.280262	0	2,783,839	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.530595	0	63,477	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.028373	0	310,234	1,303	0	64.00
66.00	06600	PHYSICAL THERAPY	0.461844	0	1,267,389	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.473468	0	307,683	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.666561	0	48,792	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.223945	0	1,545,690	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.204503	0	28,015	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.520152	0	104,528	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.355254	0	1,043,771	2,742	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.232194	0	254,609	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.291326	0	72,809	139	0	90.00
90.01	09001	OB CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0.416721	0	42,428	0	0	90.03
91.00	09100	EMERGENCY	0.563847	0	1,318,209	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.076683	0	219,777	0	0	92.00
200.00		Subtotal (see instructions)		0	16,307,578	4,184	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	16,307,578	4,184	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet D Part V Date/Time Prepared: 10/10/2016 4:39 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	784,597	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,109,076	0		54.00
60.00	06000	LABORATORY	780,204	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	33,681	0		62.00
64.00	06400	INTRAVENOUS THERAPY	8,802	37		64.00
66.00	06600	PHYSICAL THERAPY	585,336	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	145,678	0		67.00
68.00	06800	SPEECH PATHOLOGY	32,523	0		68.00
69.00	06900	ELECTROCARDIOLOGY	346,150	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,729	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	54,370	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	370,804	974		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	59,119	0		76.01
76.02	03950	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	94,020	179		90.00
90.01	09001	OB CLINIC	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
90.03	09003	SURGICAL CLINIC	17,681	0		90.03
91.00	09100	EMERGENCY	743,268	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	236,630	0		92.00
200.00		Subtotal (see instructions)	5,407,668	1,190		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,407,668	1,190		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141319 | Component CCN: 14Z319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet D Part V | Date/Time Prepared: 10/10/2016 4:39 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	0.326170	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.210242	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246964	0	0	0	0	54.00
60.00	06000	LABORATORY	0.280262	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.530595	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.028373	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.461844	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.473468	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.666561	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.223945	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.204503	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.520152	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.355254	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.232194	0	0	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.291326	0	0	0	0	90.00
90.01	09001	OB CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0.416721	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.563847	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.076683	0	0	0	0	92.00
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: 141319 | Component CCN: 14Z319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet D Part V | Date/Time Prepared: 10/10/2016 4:39 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03950	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OB CLINIC	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
90.03	09003	SURGICAL CLINIC	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2015 To 05/31/2016 | Worksheet D Part IV | Date/Time Prepared: 10/10/2016 4:39 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2015 To 05/31/2016 | Worksheet D Part IV | Date/Time Prepared: 10/10/2016 4:39 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,837,657	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	582,804	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,198,467	0.000000	0.000000	6,100	54.00
60.00	06000	LABORATORY	0	8,742,424	0.000000	0.000000	13,960	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	243,981	0.000000	0.000000	4,122	62.00
64.00	06400	INTRAVENOUS THERAPY	0	3,749,056	0.000000	0.000000	31,923	64.00
66.00	06600	PHYSICAL THERAPY	0	4,887,458	0.000000	0.000000	305,662	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,694,035	0.000000	0.000000	203,519	67.00
68.00	06800	SPEECH PATHOLOGY	0	253,561	0.000000	0.000000	34,344	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,181,401	0.000000	0.000000	2,666	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	430,609	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,480,116	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,183,428	0.000000	0.000000	153,349	73.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	971,860	0.000000	0.000000	0	76.01
76.02	03950	IV THERAPY	0	0	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	608,213	0.000000	0.000000	0	90.00
90.01	09001	OB CLINIC	0	0	0.000000	0.000000	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0.000000	0.000000	0	90.02
90.03	09003	SURGICAL CLINIC	0	1,776,437	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	4,555,228	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	492,245	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	70,868,980			755,645	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2015 To 05/31/2016 | Worksheet D Part IV | Date/Time Prepared: 10/10/2016 4:39 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.02	03950	IV THERAPY	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OB CLINIC	0	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0	0		90.02
90.03	09003	SURGICAL CLINIC	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2015 To 05/31/2016 | Worksheet D Part V | Date/Time Prepared: 10/10/2016 4:39 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.326170	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.210242	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246964	0	0	0	0	54.00
60.00	06000	LABORATORY	0.280262	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.530595	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.028373	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.461844	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.473468	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.666561	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.223945	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.204503	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.520152	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.355254	0	0	43	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.232194	0	0	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.291326	0	0	0	0	90.00
90.01	09001	OB CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0.416721	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.563847	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.076683	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	43	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	43	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2015 To 05/31/2016 | Worksheet D Part V | Date/Time Prepared: 10/10/2016 4:39 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03950	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OB CLINIC	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
90.03	09003	SURGICAL CLINIC	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	15		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	15		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet D-1 | Date/Time Prepared: 10/10/2016 4:39 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,267	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,068	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,580	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	116	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)	83	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,649	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)	108	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)	77	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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	133.47	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	133.47	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,634,161	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	216,124	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,418,037	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,418,037	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,086.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,790,896	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,790,896	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet D-1 | Date/Time Prepared: 10/10/2016 4:39 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,362,330	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,153,226	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)	117,293	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	83,626	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	200,919	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)	488	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,086.05	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	529,992	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet D-1 | Date/Time Prepared: 10/10/2016 4:39 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	526,718	4,634,161	0.113660	529,992	60,239	90.00
91.00	Nursing School cost	0	4,634,161	0.000000	529,992	0	91.00
92.00	Allied health cost	0	4,634,161	0.000000	529,992	0	92.00
93.00	All other Medical Education	0	4,634,161	0.000000	529,992	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141319 Component CCN: 145464	Period: From 06/01/2015 To 05/31/2016	Worksheet D-1 Date/Time Prepared: 10/10/2016 4:39 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,209	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,209	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	12,209	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,171	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,781,343	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,781,343	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,781,343	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2015 To 05/31/2016 | Worksheet D-1 | Date/Time Prepared: 10/10/2016 4:39 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,781,343	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	227.81	71.00
72.00	Program routine service cost (line 9 x line 71)	266,766	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	266,766	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	266,766	83.00
84.00	Program inpatient ancillary services (see instructions)	324,006	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	590,772	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141319 Component CCN: 145464	Period: From 06/01/2015 To 05/31/2016	Worksheet D-1 Date/Time Prepared: 10/10/2016 4:39 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet D-3 | Date/Time Prepared: 10/10/2016 4:39 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		1,557,728		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.326170	2,290,987	747,251	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.210242	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246964	330,297	81,571	54.00
60.00	06000	LABORATORY	0.280262	417,508	117,012	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.530595	81,647	43,321	62.00
64.00	06400	INTRAVENOUS THERAPY	0.028373	1,309,920	37,166	64.00
66.00	06600	PHYSICAL THERAPY	0.461844	171,946	79,412	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.473468	103,856	49,172	67.00
68.00	06800	SPEECH PATHOLOGY	0.666561	16,498	10,997	68.00
69.00	06900	ELECTROCARDIOLOGY	0.223945	99,593	22,303	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.204503	224,303	45,871	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.520152	1,426,303	741,894	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.355254	1,061,257	377,016	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.232194	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.291326	0	0	90.00
90.01	09001	OB CLINIC	0.000000	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	90.02
90.03	09003	SURGICAL CLINIC	0.416721	0	0	90.03
91.00	09100	EMERGENCY	0.563847	2,321	1,309	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.076683	7,463	8,035	92.00
200.00		Total (sum of lines 50-94 and 96-98)		7,543,899	2,362,330	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)		7,543,899		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141319 | Component CCN: 14Z319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet D-3 | Date/Time Prepared: 10/10/2016 4:39 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.326170	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.210242	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246964	1,095	270	54.00
60.00	06000	LABORATORY	0.280262	11,583	3,246	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.530595	1,031	547	62.00
64.00	06400	INTRAVENOUS THERAPY	0.028373	34,950	992	64.00
66.00	06600	PHYSICAL THERAPY	0.461844	37,150	17,158	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.473468	17,911	8,480	67.00
68.00	06800	SPEECH PATHOLOGY	0.666561	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.223945	289	65	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.204503	2,082	426	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.520152	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.355254	51,457	18,280	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.232194	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.291326	0	0	90.00
90.01	09001	OB CLINIC	0.000000	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	90.02
90.03	09003	SURGICAL CLINIC	0.416721	0	0	90.03
91.00	09100	EMERGENCY	0.563847	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.076683	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		157,548	49,464	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)		157,548		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet D-3

Component CCN: 145464 | Date/Time Prepared: 10/10/2016 4:39 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.326170	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.210242	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246964	6,100	1,506	54.00
60.00	06000	LABORATORY	0.280262	13,960	3,912	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.530595	4,122	2,187	62.00
64.00	06400	INTRAVENOUS THERAPY	0.028373	31,923	906	64.00
66.00	06600	PHYSICAL THERAPY	0.461844	305,662	141,168	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.473468	203,519	96,360	67.00
68.00	06800	SPEECH PATHOLOGY	0.666561	34,344	22,892	68.00
69.00	06900	ELECTROCARDIOLOGY	0.223945	2,666	597	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.204503	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.520152	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.355254	153,349	54,478	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.232194	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.291326	0	0	90.00
90.01	09001	OB CLINIC	0.000000	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	90.02
90.03	09003	SURGICAL CLINIC	0.416721	0	0	90.03
91.00	09100	EMERGENCY	0.563847	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.076683	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		755,645	324,006	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)		755,645		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141319	Period: From 06/01/2015 To 05/31/2016	Worksheet E Part B Date/Time Prepared: 10/10/2016 4:39 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,408,858	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)	5,408,858	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)	5,462,947	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)	66,632	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,671,149	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,725,166	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,725,166	30.00
31.00	Primary payer payments	141	31.00
32.00	Subtotal (line 30 minus line 31)	2,725,025	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)	49,993	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	32,495	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	49,993	36.00
37.00	Subtotal (see instructions)	2,757,520	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,757,520	40.00
40.01	Sequestration adjustment (see instructions)	55,150	40.01
41.00	Interim payments	2,751,573	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-49,203	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141319 Component CCN: 145464	Period: From 06/01/2015 To 05/31/2016	Worksheet E Part B Date/Time Prepared: 10/10/2016 4:39 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	15	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	15	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	43	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)	43	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)	43	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	28	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)	15	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)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	15	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)	15	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	15	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	15	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	15	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
41.00	Interim payments	33	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-18	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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 10/10/2016 4:39 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		3,143,189		2,751,573	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		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	05/19/2016	262,388		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)		262,388		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)		3,405,577		2,751,573	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		242,623		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		49,203	6.02
7.00	Total Medicare program liability (see instructions)		3,648,200		2,702,370	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: 141319 | Component CCN: 14Z319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 10/10/2016 4:39 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		225,006		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	05/19/2016	24,891		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)		24,891		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)		249,897		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		2,994		0	6.02
7.00	Total Medicare program liability (see instructions)		246,903		0	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: 141319 | Component CCN: 145464 | Period: From 06/01/2015 To 05/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 10/10/2016 4:39 pm

Title XVIII | Skilled Nursing Facility | 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		436,896		33	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		436,896		33	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		0		18	6.02
7.00	Total Medicare program liability (see instructions)		436,896		15	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: 141319	Period: From 06/01/2015 To 05/31/2016	Worksheet E-1 Part II Date/Time Prepared: 10/10/2016 4:39 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	1,240	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,649	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	193	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	3,580	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	77,907,601	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	352,796	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: 141319 Component CCN: 14Z319	Period: From 06/01/2015 To 05/31/2016	Worksheet E-2 Date/Time Prepared: 10/10/2016 4:39 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)	202,928	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)	49,959	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	185	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)	252,887	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	252,887	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)	252,887	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	945	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)	251,942	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)	251,942	0	19.00
19.01	Sequestration adjustment (see instructions)	5,039	0	19.01
20.00	Interim payments	249,897	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)	-2,994	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: 141319	Period: From 06/01/2015 To 05/31/2016	Worksheet E-3 Part V Date/Time Prepared: 10/10/2016 4:39 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,153,226	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)	4,153,226	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,194,758	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)	4,194,758	19.00
20.00	Deductibles (exclude professional component)	486,260	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,708,498	22.00
23.00	Coinsurance	630	23.00
24.00	Subtotal (line 22 minus line 23)	3,707,868	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	22,746	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	14,785	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	22,746	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,722,653	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)	3,722,653	30.00
30.01	Sequestration adjustment (see instructions)	74,453	30.01
31.00	Interim payments	3,405,577	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)	242,623	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141319 Component CCN: 145464	Period: From 06/01/2015 To 05/31/2016	Worksheet E-3 Part VI Date/Time Prepared: 10/10/2016 4:39 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	496,863	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	496,863	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	51,051	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	445,812	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	445,812	15.00
15.01	Sequestration adjustment (see instructions)	8,916	15.01
16.00	Interim payments	436,896	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet G | Date/Time Prepared: 10/10/2016 4:39 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	7,650,864	0	0	0	1.00
2.00	Temporary investments	1,073,494	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,497,758	0	0	0	4.00
5.00	Other receivable	465,791	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	849,489	0	0	0	7.00
8.00	Prepaid expenses	737,897	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	868,240	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	16,143,533	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	31,253,953	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)	31,253,953	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	14,263,026	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	6,997,134	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	21,260,160	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	68,657,646	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,122,618	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,840,002	0	0	0	38.00
39.00	Payroll taxes payable	431,735	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,070,389	0	0	0	40.00
41.00	Deferred income	2,794,416	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,105	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,262,265	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	28,476,827	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	502,099	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	28,978,926	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	36,241,191	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	32,416,455				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)	32,416,455	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	68,657,646	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet G-1 | Date/Time Prepared: 10/10/2016 4:39 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		33,703,811		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,287,356				2.00
3.00	Total (sum of line 1 and line 2)		32,416,455		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)		32,416,455		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		32,416,455		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	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 10/10/2016 4:39 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,841,012		3,841,012	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	2,409,232		2,409,232	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,250,244		6,250,244	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,250,244		6,250,244	17.00
18.00	Ancillary services	19,359,212	45,848,463	65,207,675	18.00
19.00	Outpatient services	1,007,409	13,366,393	14,373,802	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		851,209	851,209	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NURSERY	428,029	1,709	429,738	27.00
27.01	NRCC	0	718,626	718,626	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	27,044,894	60,786,400	87,831,294	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		39,481,648		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		39,481,648		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet G-3 | Date/Time Prepared: 10/10/2016 4:39 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	87,831,294	1.00
2.00	Less contractual allowances and discounts on patients' accounts	51,672,635	2.00
3.00	Net patient revenues (line 1 minus line 2)	36,158,659	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	39,481,648	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,322,989	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	130,691	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	691,361	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	EHR PAYMENTS	90,739	24.01
24.02	OTHER OP REV	684,144	24.02
24.03	CAPITAL CONTRIBUTIONS	309,141	24.03
24.04	GAIN ON DISPOSAL	200,249	24.04
25.00	Total other income (sum of lines 6-24)	2,106,325	25.00
26.00	Total (line 5 plus line 25)	-1,216,664	26.00
27.00	ROUNDING	316	27.00
27.01		0	27.01
27.02	LOSS ON INVESTMENT	70,376	27.02
27.03		0	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	70,692	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,287,356	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet H

HHA CCN: 147450 | Date/Time Prepared: 10/10/2016 4:39 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	102,050	0	3,036	16,660	5,562	127,308	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	337,271	0	50,077	0	0	387,348	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	30,398	0	0	0	0	30,398	11.00
12.00	Supplies (see instructions)	0	0	0	0	26,989	26,989	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
24.00	Total (sum of lines 1-23)	469,719	0	53,113	16,660	32,551	572,043	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	127,308	0	127,308			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	387,348	0	387,348			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	30,398	0	30,398			11.00
12.00	Supplies (see instructions)	0	26,989	0	26,989			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
24.00	Total (sum of lines 1-23)	0	572,043	0	572,043			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: 141319 HHA CCN: 147450 | Period: From 06/01/2015 To 05/31/2016 | Worksheet H-1 Part I Date/Time Prepared: 10/10/2016 4:39 pm

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	127,308	0	0	0	0	127,308	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	387,348	0	0	0	0	387,348	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	30,398	0	0	0	0	30,398	11.00
12.00	Supplies (see instructions)	26,989	0	0	0	0	26,989	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
24.00	Total (sum of lines 1-23)	572,043	0	0	0	0	572,043	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	127,308						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	110,880	498,228					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	8,702	39,100					11.00
12.00	Supplies (see instructions)	7,726	34,715					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
24.00	Total (sum of lines 1-23)		572,043					24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 141319 HHA CCN: 147450 | Period: From 06/01/2015 To 05/31/2016 | Worksheet H-1 Part II Date/Time Prepared: 10/10/2016 4:39 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-127,308	444,735	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	387,348	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	30,398	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	26,989	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
24.00	Total (sum of lines 1-23)	0	0	0	0	-127,308	444,735	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		127,308	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.286256	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141319 | HHA CCN: 147450 | Period: From 06/01/2015 To 05/31/2016 | Worksheet H-2 Part I | Date/Time Prepared: 10/10/2016 4:39 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES	
		0	1.00	2.00	4.00	5.01	5.02	
1.00	Administrative and General	0	25,396	267	153,511	27,569	1,781	1.00
2.00	Skilled Nursing Care	498,228	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	39,100	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	34,715	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
20.00	Total (sum of lines 1-19) (2)	572,043	25,396	267	153,511	27,569	1,781	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	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	ALL OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.03	5.04	5A.04	5.05	7.00	8.00	
1.00	Administrative and General	0	6,870	215,394	18,035	17,400	0	1.00
2.00	Skilled Nursing Care	0	0	498,228	41,715	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	39,100	3,274	0	0	7.00
8.00	Supplies (see instructions)	0	0	34,715	2,907	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
20.00	Total (sum of lines 1-19) (2)	0	6,870	787,437	65,931	17,400	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				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: 141319 | HHA CCN: 147450 | Period: From 06/01/2015 To 05/31/2016 | Worksheet H-2 Part I | Date/Time Prepared: 10/10/2016 4:39 pm

Home Health Agency I | PPS

	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	3,145	0	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
20.00	Total (sum of lines 1-19) (2)	3,145	0	0	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	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		16.00	17.00	18.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	0	253,974	0	253,974	1.00
2.00	Skilled Nursing Care	0	0	0	539,943	0	539,943	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	4,827	0	4,827	0	4,827	6.00
7.00	Home Health Aide	0	0	0	42,374	0	42,374	7.00
8.00	Supplies (see instructions)	0	0	0	37,622	0	37,622	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
20.00	Total (sum of lines 1-19) (2)	0	4,827	0	878,740	0	878,740	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: 141319 | Period: From 06/01/2015 To 05/31/2016 | Worksheet H-2 Part I | Date/Time Prepared: 10/10/2016 4:39 pm

HHA CCN: 147450 | Home Health Agency I | PPS

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs				
		27.00	28.00				
1.00	Administrative and General						1.00
2.00	Skilled Nursing Care	219,493	759,436				2.00
3.00	Physical Therapy	0	0				3.00
4.00	Occupational Therapy	0	0				4.00
5.00	Speech Pathology	0	0				5.00
6.00	Medical Social Services	1,962	6,789				6.00
7.00	Home Health Aide	17,225	59,599				7.00
8.00	Supplies (see instructions)	15,294	52,916				8.00
9.00	Drugs	0	0				9.00
10.00	DME	0	0				10.00
11.00	Home Dialysis Aide Services	0	0				11.00
12.00	Respiratory Therapy	0	0				12.00
13.00	Private Duty Nursing	0	0				13.00
14.00	Clinic	0	0				14.00
15.00	Health Promotion Activities	0	0				15.00
16.00	Day Care Program	0	0				16.00
17.00	Home Delivered Meals Program	0	0				17.00
18.00	Homemaker Service	0	0				18.00
19.00	All Others (specify)	0	0				19.00
20.00	Total (sum of lines 1-19) (2)	253,974	878,740				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.	0.406511					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: 141319 HHA CCN: 147450

Period: From 06/01/2015 To 05/31/2016

Worksheet H-2 Part II Date/Time Prepared: 10/10/2016 4:39 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COST)	ADMITTING (GROSS CHARGES)	
		1.00	2.00	4.00	5.01	5.02	5.03	
1.00	Administrative and General	1,008	247	469,719	4,050	30,201	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
20.00	Total (sum of lines 1-19)	1,008	247	469,719	4,050	30,201	0	20.00
21.00	Total cost to be allocated	25,396	267	153,511	27,569	1,781	0	21.00
22.00	Unit cost multiplier	25.194444	1.080972	0.326815	6.807160	0.058972	0.000000	22.00

	Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	ALL OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5.04	5A.05	5.05	7.00	8.00	9.00	
1.00	Administrative and General	851,209	0	215,394	1,008	0	2,160	1.00
2.00	Skilled Nursing Care	0	0	498,228	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	39,100	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	34,715	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
20.00	Total (sum of lines 1-19)	851,209		787,437	1,008	0	2,160	20.00
21.00	Total cost to be allocated	6,870		65,931	17,400	0	3,145	21.00
22.00	Unit cost multiplier	0.008071		0.083729	17.261905	0.000000	1.456019	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141319 HHA CCN: 147450

Period: From 06/01/2015 To 05/31/2016

Worksheet H-2 Part II Date/Time Prepared: 10/10/2016 4:39 pm

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	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	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
20.00	Total (sum of lines 1-19)	0	0	0	0	0	0	20.00
21.00	Total cost to be allocated	0	0	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

	Cost Center Description	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE INSERVICE EDUCATION (GROSS CHARGES)					
		17.00	18.00					
1.00	Administrative and General	0	0					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	1,500	0					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
20.00	Total (sum of lines 1-19)	1,500	0					20.00
21.00	Total cost to be allocated	4,827	0					21.00
22.00	Unit cost multiplier	3.218000	0.000000					22.00

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	759,436		759,436	5,022	151.22	1.00
2.00	Physical Therapy	3.00	0	140,915	140,915	1,724	81.74	2.00
3.00	Occupational Therapy	4.00	0	72,814	72,814	889	81.91	3.00
4.00	Speech Pathology	5.00	0	25,203	25,203	210	120.01	4.00
5.00	Medical Social Services	6.00	6,789		6,789	15	452.60	5.00
6.00	Home Health Aide	7.00	59,599		59,599	1,363	43.73	6.00
7.00	Total (sum of lines 1-6)		825,824	238,932	1,064,756	9,223		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		19340	0	3,284			8.00
8.01	Skilled Nursing Care		99914	0	116			8.01
9.00	Physical Therapy		19340	0	1,119			9.00
9.01	Physical Therapy		99914	0	31			9.01
10.00	Occupational Therapy		19340	0	604			10.00
10.01	Occupational Therapy		99914	0	19			10.01
11.00	Speech Pathology		19340	0	170			11.00
11.01	Speech Pathology		99914	0	4			11.01
12.00	Medical Social Services		19340	0	15			12.00
12.01	Medical Social Services		99914	0	0			12.01
13.00	Home Health Aide		19340	0	974			13.00
13.01	Home Health Aide		99914	0	106			13.01
14.00	Total (sum of lines 8-13)			0	6,442			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	52,916	0	52,916	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	3,400		0	514,148		1.00
2.00	Physical Therapy	0	1,150		0	94,001		2.00
3.00	Occupational Therapy	0	623		0	51,030		3.00
4.00	Speech Pathology	0	174		0	20,882		4.00
5.00	Medical Social Services	0	15		0	6,789		5.00
6.00	Home Health Aide	0	1,080		0	47,228		6.00
7.00	Total (sum of lines 1-6)	0	6,442		0	734,078		7.00

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	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

		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs	0	0	0		0	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	514,148						1.00
2.00	Physical Therapy	94,001						2.00
3.00	Occupational Therapy	51,030						3.00
4.00	Speech Pathology	20,882						4.00
5.00	Medical Social Services	6,789						5.00
6.00	Home Health Aide	47,228						6.00
7.00	Total (sum of lines 1-6)	734,078						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: 141319 HHA CCN: 147450 | Period: From 06/01/2015 To 05/31/2016 | Worksheet H-3 Part II Date/Time Prepared: 10/10/2016 4:39 pm

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	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	0.461844	305,114	140,915	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.473468	153,788	72,814	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.666561	37,810	25,203	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.204503	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.355254	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 141319 | HHA CCN: 147450 | Period: From 06/01/2015 To 05/31/2016 | Worksheet H-4 Part I-II | Date/Time Prepared: 10/10/2016 4:39 pm

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		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	0	0	1.00
2.00	Total charges	302,635	566,832	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)	302,635	566,832	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	302,635	566,832	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	917,362	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	27,436	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	20,044	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	4,964	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	3,552	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	973,358	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	973,358	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	973,358	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	973,358	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	973,358	31.00
31.01	Sequestration adjustment (see instructions)	0	19,467	31.01
32.00	Interim payments (see instructions)	0	953,891	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 141319 HHA CCN: 147450 | Period: From 06/01/2015 To 05/31/2016 | Worksheet H-5 | Date/Time Prepared: 10/10/2016 4:39 pm

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		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		953,891	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		953,891	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		953,891	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00