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: 141349	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/21/2016 7:28 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/21/2016 Time: 7:28 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SPARTA COMMUNITY HOSPITAL (141349) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	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	48,796	-175,208	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	64,220	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		274,421		0	10.00
200.00	Total	0	113,016	99,213	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: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2016 7:26 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 818 EAST BROADWAY	PO Box:			1.00
2.00	City: SPARTA	State: IL	Zip Code: 62286	County: RANDOLPH	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	SPARTA COMMUNITY HOSPITAL	141349	99914	1	11/01/2005	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SPARTA COMMUNITY SWING BED	14Z349	99914		11/01/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	SPARTA COMMUNITY HHA	147694	99914		08/07/1998	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	WOMEN'S HEALTH CLINIC NORTH CAMPUS	143464	99914		10/06/2004	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2015	06/30/2016	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2016 7:26 pm

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

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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

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

		1.00	
	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)	N	N	0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2016 7:26 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)	N	N	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)	N	N	0	76.00

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	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	Y	Y	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:	429,051	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: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2016 7:26 pm

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

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

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

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

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

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

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141349	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/21/2016 7:26 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2015	09/30/2015	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: 141349	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/21/2016 7:26 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/03/2016	Y	10/03/2016	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 11/21/2016 7:26 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	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.	PATTY	RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544	211 N BROADWAY STE 600, ST LOUIS, MO	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 141349	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/21/2016 7:26 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2016 7:26 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	22,767.00	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	22,767.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,150	22,767.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				4,034	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2016 7:26 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	626	68	863			1.00
2.00	HMO and other (see instructions)	28	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	549	0	549			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	206			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,175	68	1,618			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)	1,175	68	1,618	0.00	180.93	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	7,796	0.00	10.43	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	23			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	11,934	0	46,186	0.00	64.76	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	256.12	27.00
28.00	Observation Bed Days		92	553			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			2			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2016 7:26 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	239	32	344	1.00
2.00	HMO and other (see instructions)			11	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	239	32	344	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	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: 141349 | Component CCN: 147694 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-4 | Date/Time Prepared: 11/21/2016 7:26 pm

Home Health Agency I | PPS

		1.00	
0.00	County		0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	276.00	42.00	109.00	427.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			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		3.56	0.00	3.56	5.00
6.00	Direct Nursing Service		4.33	0.00	4.33	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		2.50	0.00	2.50	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.03	0.03	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.01	0.01	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.01	0.00	0.01	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.		3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99914			20.00
20.01			41180			20.01
20.02			16060			20.02

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,817	16	42	40	1,915	21.00
22.00	Skilled Nursing Visit Charges	483,433	4,206	12,054	10,925	510,618	22.00
23.00	Physical Therapy Visits	1,926	24	12	55	2,017	23.00
24.00	Physical Therapy Visit Charges	411,433	5,035	3,595	11,803	431,866	24.00
25.00	Occupational Therapy Visits	58	8	0	0	66	25.00
26.00	Occupational Therapy Visit Charges	12,366	16,206	0	0	28,572	26.00
27.00	Speech Pathology Visits	27	0	0	0	27	27.00
28.00	Speech Pathology Visit Charges	7,243	0	0	0	7,243	28.00
29.00	Medical Social Service Visits	1	0	0	0	1	29.00
30.00	Medical Social Service Visit Charges	391	0	0	0	391	30.00
31.00	Home Health Aide Visits	8	0	0	0	8	31.00
32.00	Home Health Aide Visit Charges	1,188	0	0	0	1,188	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,837	48	54	95	4,034	33.00
34.00	Other Charges	18,153	24	234	64	18,475	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	934,207	25,471	15,883	22,792	998,353	35.00
36.00	Total Number of Episodes (standard/non outlier)	234		18	8	260	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

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

Provider CCN: 141349 Component CCN: 143464 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-8 | Date/Time Prepared: 11/21/2016 7:26 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1300 NORTH MARKET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	SPARTA	IL	62286	2.00

		1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic	09:00	14:00	09:00	19:00	09:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y	6	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number	WOMENS HEALTH CLINIC	143464	14.00
14.01		COULTERVILLE MEDICAL CLINIC	143465	14.01
14.02		FAMILY HEALTH CLINIC	143466	14.02
14.03		STEELEVILLE CLINIC	143467	14.03
14.04		MARISSA MEDICAL CLINIC	143490	14.04
14.05		SPARTA MEDICAL OFFICE	143489	14.05

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

		County		
		4.00		
2.00	City, State, ZIP Code, County	RANDOLPH		2.00

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

Provider CCN: 141349 Component CCN: 143464

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

Worksheet S-8

Date/Time Prepared: 11/21/2016 7:26 pm

Rural Health Clinic (RHC) I

Cost

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	19:00	09:00	19:00	09:00	19:00	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	19:00	09:00	16:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-10 | Date/Time Prepared: 11/21/2016 7:26 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)	0.411299	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,361,909	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	2,210,212	5.00
6.00	Medicaid charges	11,457,351	6.00
7.00	Medicaid cost (line 1 times line 6)	4,712,397	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	15,200	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	75,432	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	63,830	0	63,830	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	26,253	0	26,253	21.00
22.00	Partial payment by patients approved for charity care	20,680	0	20,680	22.00
23.00	Cost of charity care (line 21 minus line 22)	5,573	0	5,573	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)	2,986,646	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	293,059	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,693,587	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,107,870	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,113,443	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,113,443	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/21/2016 7:26 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		750,507	750,507	-42,847	707,660	1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG		0	0	188,550	188,550	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,319,543	1,319,543	26,295	1,345,838	2.00
3.00	00300	OTHER CAP RELATED COST		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,532,839	3,532,839	0	3,532,839	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,747,364	2,721,570	5,468,934	-103,407	5,365,527	5.00
6.00	00600	MAINTENANCE & REPAIRS	195,294	11,718	207,012	0	207,012	6.00
7.00	00700	OPERATION OF PLANT	0	448,196	448,196	0	448,196	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	46,237	46,237	0	46,237	8.00
9.00	00900	HOUSEKEEPING	220,663	137,222	357,885	0	357,885	9.00
10.00	01000	DIETARY	148,526	117,515	266,041	36,812	302,853	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	118,379	3,998	122,377	0	122,377	13.00
15.00	01500	PHARMACY	0	1,594,442	1,594,442	0	1,594,442	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	285,467	55,644	341,111	0	341,111	16.00
17.00	01700	SOCIAL SERVICE	39,952	769	40,721	0	40,721	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	588,744	588,744	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	979,104	554,773	1,533,877	-13,790	1,520,087	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	543,001	845,254	1,388,255	-388,424	999,831	50.00
53.00	05300	ANESTHESIOLOGY	223,173	419,084	642,257	-597,525	44,732	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	449,655	198,981	648,636	-63,265	585,371	54.00
54.01	05401	ULTRASOUND	95,993	57,536	153,529	135	153,664	54.01
56.00	05600	RADIOISOTOPE	0	378,286	378,286	4,546	382,832	56.00
57.00	05700	CT SCAN	0	108,153	108,153	40,674	148,827	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	37,418	37,418	22,591	60,009	58.00
60.00	06000	LABORATORY	493,795	892,200	1,385,995	-11,725	1,374,270	60.00
65.00	06500	RESPIRATORY THERAPY	48,185	33,403	81,588	0	81,588	65.00
66.00	06600	PHYSICAL THERAPY	594,885	97,125	692,010	-379	691,631	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	26,236	2,755	28,991	7,044	36,035	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,030	6,030	126,364	132,394	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	320,382	320,382	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	120,700	120,700	0	120,700	75.01
75.02	03952	WOUND CENTER	0	68,819	68,819	0	68,819	75.02
76.00	03953	CARDIAC REHAB	86,877	6,235	93,112	0	93,112	76.00
76.01	03030	DIABETES EDUCATION	81,717	5,559	87,276	-36,812	50,464	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,870,530	1,511,993	5,382,523	47,226	5,429,749	88.00
91.00	09100	EMERGENCY	675,280	1,082,500	1,757,780	-35,751	1,722,029	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	578,816	163,588	742,404	0	742,404	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		114,212	114,212	-114,212	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,502,892	17,444,804	29,947,696	1,226	29,948,922	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	472,761	130,392	603,153	-1,226	601,927	194.00
200.00		TOTAL (SUM OF LINES 118-199)	12,975,653	17,575,196	30,550,849	0	30,550,849	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/21/2016 7:26 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	-43,479	664,181		1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	0	188,550		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-141,481	1,204,357		2.00
3.00	00300	OTHER CAP RELATED COST	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-638,310	2,894,529		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-673,210	4,692,317		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	207,012		6.00
7.00	00700	OPERATION OF PLANT	0	448,196		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	46,237		8.00
9.00	00900	HOUSEKEEPING	0	357,885		9.00
10.00	01000	DIETARY	-41,373	261,480		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	122,377		13.00
15.00	01500	PHARMACY	-591,739	1,002,703		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,917	338,194		16.00
17.00	01700	SOCIAL SERVICE	0	40,721		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-588,744	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-411,016	1,109,071		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	999,831		50.00
53.00	05300	ANESTHESIOLOGY	0	44,732		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	-1,386	583,985		54.00
54.01	05401	ULTRASOUND	0	153,664		54.01
56.00	05600	RADIOISOTOPE	0	382,832		56.00
57.00	05700	CT SCAN	0	148,827		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	60,009		58.00
60.00	06000	LABORATORY	0	1,374,270		60.00
65.00	06500	RESPIRATORY THERAPY	0	81,588		65.00
66.00	06600	PHYSICAL THERAPY	0	691,631		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	36,035		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-6	132,388		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	320,382		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		75.00
75.01	03951	SLEEP LAB	0	120,700		75.01
75.02	03952	WOUND CENTER	0	68,819		75.02
76.00	03953	CARDIAC REHAB	0	93,112		76.00
76.01	03030	DIABETES EDUCATION	0	50,464		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-62,777	5,366,972		88.00
91.00	09100	EMERGENCY	-325,697	1,396,332		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	742,404		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,522,135	26,426,787		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
194.00	07950	FREESTANDING CLINICS	0	601,927		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-3,522,135	27,028,714		200.00

RECLASSIFICATIONS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/21/2016 7:26 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS COST OF SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	126,364		1.00
2.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	320,382		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		0	446,746		
	B - TO RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	113,071		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,141		2.00
	0		0	114,212		
	C - TO RECLASS EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	11,725	0		1.00
	0		11,725	0		
	D - TO RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP RELATED COST	3.00	0	58,927		1.00
	0		0	58,927		
	E - TO RECLASS TELEPHONE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,030		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	16,030		
	G - TO RECLASS CRNA EXPENSES					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	223,173	365,571		1.00
	0		223,173	365,571		
	H - TO RECLASS NORTHCAMPUS BLDG					
1.00	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	182,535		1.00
	0		0	182,535		
	I - TO RECLASS CT SCAN					
1.00	CT SCAN	57.00	40,674	0		1.00
	0		40,674	0		
	J - TO RECLASS RECRUITMENT EXPENSE					
1.00	RURAL HEALTH CLINIC	88.00	0	61,651		1.00
	0		0	61,651		
	K - TO RECLASS STRESS TEST SALARIES					
1.00	RADIOISOTOPE	56.00	4,546	0		1.00
2.00	ULTRASOUND	54.01	135	0		2.00
	0		4,681	0		
	L - TO RECLASS MRI SALARIES					
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	22,591	0		1.00
	0		22,591	0		
	M - TO RECLASS DIETARY SALARIES					
1.00	DIETARY	10.00	36,812	0		1.00
	TOTALS		36,812	0		
500.00	Grand Total: Increases		339,656	1,245,672		500.00

RECLASSIFICATIONS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/21/2016 7:26 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS COST OF SUPPLIES						
1.00	OPERATING ROOM	50.00	0	388,424	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	13,790	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	8,781	0		3.00
4.00	EMERGENCY	91.00	0	35,751	0		4.00
	0		0	446,746			
	B - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	114,212	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	114,212			
	C - TO RECLASS EKG SALARIES						
1.00	LABORATORY	60.00	11,725	0	0		1.00
	0		11,725	0			
	D - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	58,927	12		1.00
	0		0	58,927			
	E - TO RECLASS TELEPHONE EXPENSE						
1.00	PHYSICAL THERAPY	66.00	0	379	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	14,425	0		2.00
3.00	FREESTANDING CLINICS	194.00	0	1,226	0		3.00
	0		0	16,030			
	G - TO RECLASS CRNA EXPENSES						
1.00	ANESTHESIOLOGY	53.00	223,173	365,571	0		1.00
	0		223,173	365,571			
	H - TO RECLASS NORTHCAMPUS BLDG						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	182,535	9		1.00
	0		0	182,535			
	I - TO RECLASS CT SCAN						
1.00	RADIOLOGY - DIAGNOSTIC	54.00	40,674	0	0		1.00
	0		40,674	0			
	J - TO RECLASS RECRUITMENT EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	61,651	0		1.00
	0		0	61,651			
	K - TO RECLASS STRESS TEST SALARIES						
1.00	ELECTROCARDIOLOGY	69.00	4,681	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		4,681	0			
	L - TO RECLASS MRI SALARIES						
1.00	RADIOLOGY - DIAGNOSTIC	54.00	22,591	0	0		1.00
	0		22,591	0			
	M - TO RECLASS DIETARY SALARIES						
1.00	DIABETES EDUCATION	76.01	36,812	0	0		1.00
	TOTALS		36,812	0			
500.00	Grand Total: Decreases		339,656	1,245,672			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 11/21/2016 7:26 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	236,334	0	0	0	0	1.00
2.00	Land Improvements	763,834	112,368	0	112,368	30,491	2.00
3.00	Buildings and Fixtures	16,500,027	210,677	0	210,677	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	12,796,297	1,097,026	0	1,097,026	637,759	6.00
7.00	HIT designated Assets	891,921	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,188,413	1,420,071	0	1,420,071	668,250	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	31,188,413	1,420,071	0	1,420,071	668,250	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	236,334	0	1.00
2.00	Land Improvements	845,711	0	2.00
3.00	Buildings and Fixtures	16,710,704	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	13,255,564	0	6.00
7.00	HIT designated Assets	891,921	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,940,234	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	31,940,234	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 11/21/2016 7:26 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	750,507	0	0	0	0	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	1,319,543	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,070,050	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	750,507	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,319,543	2.00
3.00	Total (sum of lines 1-2)	0	2,070,050	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part III | Date/Time Prepared: 11/21/2016 7:26 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	14,320,338	0	14,320,338	0.451690	26,617	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	3,236,076	0	3,236,076	0.102072	6,015	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	14,147,485	0	14,147,485	0.446238	26,295	2.00
3.00	Total (sum of lines 1-2)	31,703,899	0	31,703,899	1.000000	58,927	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	26,617	567,972	0	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	6,015	182,535	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	26,295	1,178,062	0	2.00
3.00	Total (sum of lines 1-2)	0	0	58,927	1,928,569	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	69,592	26,617	0	0	664,181	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	6,015	0	0	188,550	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	26,295	0	0	1,204,357	2.00
3.00	Total (sum of lines 1-2)	69,592	58,927	0	0	2,057,088	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/21/2016 7:26 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-43,479	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - CAP REL COSTS-NORTH CAMPUS BLDG (chapter 2)		0	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	1.01
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)	B	-439	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-49,983	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-790,376			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-41,373	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-6	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,917	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-NORTH CAMPUS BLDG		0	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-588,744	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/21/2016 7:26 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-139,814	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	BILL COPY CHARGES	B	-9,843	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-9,101	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	TRANSMED SERVICE REVENUE	B	-4,954	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	340B CONTRACT EXPENSES	A	-591,739	PHARMACY	15.00	0	33.03
33.04	PERSONAL USE OF AUTO	A	-5,086	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	CRNA BENEFITS	A	-28,965	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.05
33.06	MARKETING SALARY	A	-38,704	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MARKETING EXPENSES	A	-134,343	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MARKETING EMPLOYEE BENEFITS	A	-10,483	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	INSURANCE DIVIDEND	B	-392,384	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	LOBBYING EXPENSES	A	-10,498	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	SELF INSURANCE EXPENSE	A	-534,319	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	SELF INSURANCE EXPENS RHC	A	-64,543	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	HOSPICE CONTRACT REVENUE	B	-10,500	ADULTS & PEDIATRICS	30.00	0	33.13
33.14	USAC SUBSIDY	B	-16,995	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	EMPLOYEE ACTIVITIES	B	-880	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	340B CONTRACT DEPRECIATION	A	-1,667	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,522,135				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: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 11/21/2016 7:26 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	436,516	400,516	36,000	0	0	1.00
2.00	91.00	EMERGENCY	948,799	325,697	623,102	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	24,000	0	24,000	0	0	3.00
4.00	54.00	RADIOLOGY - DIAGNOSTIC	1,386	1,386	0	0	0	4.00
5.00	60.00	LABORATORY	20,400	0	20,400	0	0	5.00
6.00	88.00	RURAL HEALTH CLINIC	62,777	62,777	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,493,878	790,376	703,502		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	400,516		1.00
2.00	91.00	EMERGENCY	0	0	0	325,697		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0		3.00
4.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	1,386		4.00
5.00	60.00	LABORATORY	0	0	0	0		5.00
6.00	88.00	RURAL HEALTH CLINIC	0	0	0	62,777		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	790,376		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2016 7:26 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		0	1.00
2.00	Line 1 multiplied by 15 hours per week		0	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.00	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	75.07	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.54	37.54	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	169	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	169	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	169	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	169	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141349	Period: From 07/01/2015 To 06/30/2016	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/21/2016 7:26 pm

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	75.07	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		169	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		169	63.00
64.00	Total cost of outside supplier services (from your records)		135	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		0	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		0	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2016 7:26 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					39	1.00
2.00	Line 1 multiplied by 15 hours per week					585	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	278.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.14	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.07	36.07	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					20,091	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					20,091	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					20,091	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					72.14	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					42,202	22.00
23.00	Total salary equivalency (see instructions)					42,202	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2016 7:26 pm

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						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.14	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	42,202		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	42,202		63.00
64.00	Total cost of outside supplier services (from your records)	15,870		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/21/2016 7:26 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS NORTH CAMPUS BLDG	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	664,181	664,181				1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	188,550	0	188,550			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,204,357			1,204,357		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,894,529	0	0	0	2,894,529	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,692,317	63,809	38,182	261,787	616,683	5.00
6.00	00600	MAINTENANCE & REPAIRS	207,012	31,486	0	498	44,462	6.00
7.00	00700	OPERATION OF PLANT	448,196	53,668	5,213	58,620	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,237	4,953	0	0	0	8.00
9.00	00900	HOUSEKEEPING	357,885	6,730	0	437	50,238	9.00
10.00	01000	DIETARY	261,480	15,489	0	7,149	42,196	10.00
11.00	01100	CAFETERIA	0	8,609	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	122,377	2,885	0	84	26,951	13.00
15.00	01500	PHARMACY	1,002,703	4,342	0	1,477	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	338,194	14,098	9,495	7,669	64,992	16.00
17.00	01700	SOCIAL SERVICE	40,721	0	0	0	9,096	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,109,071	62,531	0	38,800	222,911	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	999,831	58,376	0	88,993	123,624	50.00
53.00	05300	ANESTHESIOLOGY	44,732	827	0	292	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	583,985	11,664	0	125,024	87,969	54.00
54.01	05401	ULTRASOUND	153,664	3,374	0	36,013	21,885	54.01
56.00	05600	RADIOISOTOPE	382,832	2,707	0	0	1,035	56.00
57.00	05700	CT SCAN	148,827	3,402	0	113,004	9,260	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	60,009	8,722	0	215,215	5,143	58.00
60.00	06000	LABORATORY	1,374,270	16,909	0	31,350	109,752	60.00
65.00	06500	RESPIRATORY THERAPY	81,588	1,720	0	5,354	10,970	65.00
66.00	06600	PHYSICAL THERAPY	691,631	4,521	78,756	23,289	135,436	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	36,035	1,635	0	0	7,577	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	132,388	5,367	0	449	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	320,382	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	120,700	5,339	0	1,226	0	75.01
75.02	03952	WOUND CENTER	68,819	13,957	0	0	0	75.02
76.00	03953	CARDIAC REHAB	93,112	8,450	0	5,127	19,779	76.00
76.01	03030	DIABETES EDUCATION	50,464	1,776	0	0	10,223	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,366,972	132,338	56,904	104,435	881,196	88.00
91.00	09100	EMERGENCY	1,396,332	28,027	0	55,038	153,740	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	742,404	15,424	0	7,011	131,778	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,426,787	593,135	188,550	1,188,341	2,786,896	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,880	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	601,927	69,166	0	16,016	107,633	194.00
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)	27,028,714	664,181	188,550	1,204,357	2,894,529	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/21/2016 7:26 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4A	5.00	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,672,778	5,672,778				5.00
6.00	00600	MAINTENANCE & REPAIRS	283,458	75,295	358,753			6.00
7.00	00700	OPERATION OF PLANT	565,697	150,266	32,324	748,287		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	51,190	13,598	2,983	13,435	81,206	8.00
9.00	00900	HOUSEKEEPING	415,290	110,313	4,053	18,253	0	9.00
10.00	01000	DIETARY	326,314	86,679	9,329	42,012	40	10.00
11.00	01100	CAFETERIA	8,609	2,287	5,185	23,351	0	11.00
13.00	01300	NURSING ADMINISTRATION	152,297	40,455	1,738	7,826	0	13.00
15.00	01500	PHARMACY	1,008,522	267,894	2,615	11,778	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	434,448	115,402	8,491	38,239	0	16.00
17.00	01700	SOCIAL SERVICE	49,817	13,233	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,433,313	380,731	37,662	169,604	26,465	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,270,824	337,569	35,160	158,335	12,762	50.00
53.00	05300	ANESTHESIOLOGY	45,851	12,179	498	2,243	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	808,642	214,800	7,025	31,636	4,053	54.00
54.01	05401	ULTRASOUND	214,936	57,093	2,032	9,152	3,564	54.01
56.00	05600	RADIOISOTOPE	386,574	102,686	1,630	7,342	971	56.00
57.00	05700	CT SCAN	274,493	72,914	2,049	9,228	4,126	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	289,089	76,791	5,253	23,657	2,649	58.00
60.00	06000	LABORATORY	1,532,281	407,020	10,184	45,861	0	60.00
65.00	06500	RESPIRATORY THERAPY	99,632	26,465	1,036	4,665	0	65.00
66.00	06600	PHYSICAL THERAPY	933,633	248,001	2,723	12,262	9,126	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	45,247	12,019	985	4,436	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	138,204	36,711	3,232	14,556	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	320,382	85,103	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	127,265	33,805	3,215	14,480	0	75.01
75.02	03952	WOUND CENTER	82,776	21,988	8,406	0	0	75.02
76.00	03953	CARDIAC REHAB	126,468	33,594	5,089	0	0	76.00
76.01	03030	DIABETES EDUCATION	62,463	16,592	1,070	4,818	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,541,845	1,737,711	95,825	0	1,332	88.00
91.00	09100	EMERGENCY	1,633,137	433,810	16,881	76,019	16,118	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	896,617	238,168	9,290	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,232,092	5,461,172	315,963	743,188	81,206	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,880	499	1,132	5,099	0	190.00
194.00	07950	FREESTANDING CLINICS	794,742	211,107	41,658	0	0	194.00
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)	27,028,714	5,672,778	358,753	748,287	81,206	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/21/2016 7:26 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
			9.00	10.00	11.00	13.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	547,909					9.00
10.00	01000	DIETARY	828	465,202				10.00
11.00	01100	CAFETERIA	9,210	351,867	400,509			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	23,301	225,617		13.00
15.00	01500	PHARMACY	2,570	0	24,145	0	1,317,524	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,085	0	86,956	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	844	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	95,085	113,335	77,333	101,999	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	74,391	0	47,278	48,744	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	11,933	0	16,041	0	0	54.00
54.01	05401	ULTRASOUND	928	0	2,870	0	0	54.01
56.00	05600	RADIOISOTOPE	2,352	0	1,857	0	0	56.00
57.00	05700	CT SCAN	3,034	0	5,910	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	2,026	0	0	58.00
60.00	06000	LABORATORY	28,307	0	52,850	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	821	0	13,846	4,564	0	65.00
66.00	06600	PHYSICAL THERAPY	37,778	0	338	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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,317,524	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	1,232	0	0	0	0	75.01
75.02	03952	WOUND CENTER	964	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	9,035	0	4,897	0	0	76.00
76.01	03030	DIABETES EDUCATION	678	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	147,984	0	8,949	0	0	88.00
91.00	09100	EMERGENCY	55,190	0	27,185	70,310	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	4,537	0	675	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	495,942	465,202	397,301	225,617	1,317,524	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	51,967	0	3,208	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	547,909	465,202	400,509	225,617	1,317,524	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/21/2016 7:26 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	692,621					16.00
17.00	01700	SOCIAL SERVICE	0	63,894				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,792	63,894	0	2,549,213	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	53,303	0	0	2,038,366	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	60,771	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	31,599	0	0	1,125,729	0	54.00
54.01	05401	ULTRASOUND	6,064	0	0	296,639	0	54.01
56.00	05600	RADIOISOTOPE	3,511	0	0	506,923	0	56.00
57.00	05700	CT SCAN	8,937	0	0	380,691	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,426	0	0	404,891	0	58.00
60.00	06000	LABORATORY	41,174	0	0	2,117,677	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	151,029	0	65.00
66.00	06600	PHYSICAL THERAPY	20,108	0	0	1,263,969	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	62,687	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	192,703	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	405,485	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,317,524	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	4,788	0	0	184,785	0	75.01
75.02	03952	WOUND CENTER	6,064	0	0	120,198	0	75.02
76.00	03953	CARDIAC REHAB	319	0	0	179,402	0	76.00
76.01	03030	DIABETES EDUCATION	0	0	0	85,621	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	361,314	0	0	8,894,960	0	88.00
91.00	09100	EMERGENCY	73,092	0	0	2,401,742	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,149,287	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	665,491	63,894	0	25,890,292	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	8,610	0	190.00
194.00	07950	FREESTANDING CLINICS	27,130	0	0	1,129,812	0	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	692,621	63,894	0	27,028,714	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/21/2016 7:26 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,549,213		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,038,366		50.00
53.00	05300	ANESTHESIOLOGY	60,771		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,125,729		54.00
54.01	05401	ULTRASOUND	296,639		54.01
56.00	05600	RADIOISOTOPE	506,923		56.00
57.00	05700	CT SCAN	380,691		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	404,891		58.00
60.00	06000	LABORATORY	2,117,677		60.00
65.00	06500	RESPIRATORY THERAPY	151,029		65.00
66.00	06600	PHYSICAL THERAPY	1,263,969		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	62,687		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	192,703		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	405,485		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,317,524		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		75.00
75.01	03951	SLEEP LAB	184,785		75.01
75.02	03952	WOUND CENTER	120,198		75.02
76.00	03953	CARDIAC REHAB	179,402		76.00
76.01	03030	DIABETES EDUCATION	85,621		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	8,894,960		88.00
91.00	09100	EMERGENCY	2,401,742		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	1,149,287		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	25,890,292		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	8,610		190.00
194.00	07950	FREESTANDING CLINICS	1,129,812		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	27,028,714		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/21/2016 7:26 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	111,448	63,809	38,182	261,787	475,226	5.00
6.00	00600	MAINTENANCE & REPAIRS	244	31,486	0	498	32,228	6.00
7.00	00700	OPERATION OF PLANT	46	53,668	5,213	58,620	117,547	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,953	0	0	4,953	8.00
9.00	00900	HOUSEKEEPING	0	6,730	0	437	7,167	9.00
10.00	01000	DIETARY	0	15,489	0	7,149	22,638	10.00
11.00	01100	CAFETERIA	0	8,609	0	0	8,609	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,885	0	84	2,969	13.00
15.00	01500	PHARMACY	6,018	4,342	0	1,477	11,837	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,098	9,495	7,669	31,262	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,983	62,531	0	38,800	121,314	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	76,579	58,376	0	88,993	223,948	50.00
53.00	05300	ANESTHESIOLOGY	0	827	0	292	1,119	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	105	11,664	0	125,024	136,793	54.00
54.01	05401	ULTRASOUND	0	3,374	0	36,013	39,387	54.01
56.00	05600	RADIOISOTOPE	0	2,707	0	0	2,707	56.00
57.00	05700	CT SCAN	0	3,402	0	113,004	116,406	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	8,722	0	215,215	223,937	58.00
60.00	06000	LABORATORY	0	16,909	0	31,350	48,259	60.00
65.00	06500	RESPIRATORY THERAPY	9,470	1,720	0	5,354	16,544	65.00
66.00	06600	PHYSICAL THERAPY	0	4,521	78,756	23,289	106,566	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	1,635	0	0	1,635	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,367	0	449	5,816	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	5,339	0	1,226	6,565	75.01
75.02	03952	WOUND CENTER	0	13,957	0	0	13,957	75.02
76.00	03953	CARDIAC REHAB	0	8,450	0	5,127	13,577	76.00
76.01	03030	DIABETES EDUCATION	0	1,776	0	0	1,776	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	15,596	132,338	56,904	104,435	309,273	88.00
91.00	09100	EMERGENCY	0	28,027	0	55,038	83,065	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	15,424	0	7,011	22,435	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	239,489	593,135	188,550	1,188,341	2,209,515	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,880	0	0	1,880	190.00
194.00	07950	FREESTANDING CLINICS	98	69,166	0	16,016	85,280	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	239,587	664,181	188,550	1,204,357	2,296,675	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/21/2016 7:26 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	5.00	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	475,226				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	6,308	38,536			6.00
7.00	00700	OPERATION OF PLANT	0	12,588	3,472	133,607		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,139	320	2,399	8,811	8.00
9.00	00900	HOUSEKEEPING	0	9,241	435	3,259	0	9.00
10.00	01000	DIETARY	0	7,261	1,002	7,501	4	10.00
11.00	01100	CAFETERIA	0	192	557	4,169	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,389	187	1,397	0	13.00
15.00	01500	PHARMACY	0	22,443	281	2,103	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,668	912	6,828	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,109	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	31,896	4,046	30,283	2,871	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	28,280	3,777	28,271	1,385	50.00
53.00	05300	ANESTHESIOLOGY	0	1,020	54	401	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	17,995	755	5,649	440	54.00
54.01	05401	ULTRASOUND	0	4,783	218	1,634	387	54.01
56.00	05600	RADIOISOTOPE	0	8,602	175	1,311	105	56.00
57.00	05700	CT SCAN	0	6,108	220	1,648	448	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	6,433	564	4,224	287	58.00
60.00	06000	LABORATORY	0	34,098	1,094	8,189	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,217	111	833	0	65.00
66.00	06600	PHYSICAL THERAPY	0	20,776	292	2,189	990	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	1,007	106	792	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,075	347	2,599	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	7,129	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	2,832	345	2,585	0	75.01
75.02	03952	WOUND CENTER	0	1,842	903	0	0	75.02
76.00	03953	CARDIAC REHAB	0	2,814	547	0	0	76.00
76.01	03030	DIABETES EDUCATION	0	1,390	115	860	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	145,570	10,293	0	145	88.00
91.00	09100	EMERGENCY	0	36,342	1,813	13,573	1,749	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	19,952	998	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	457,499	33,939	132,697	8,811	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	42	122	910	0	190.00
194.00	07950	FREESTANDING CLINICS	0	17,685	4,475	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	475,226	38,536	133,607	8,811	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/21/2016 7:26 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
			9.00	10.00	11.00	13.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	20,102					9.00
10.00	01000	DIETARY	30	38,436				10.00
11.00	01100	CAFETERIA	338	29,072	42,937			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,498	10,440		13.00
15.00	01500	PHARMACY	94	0	2,589	0	39,347	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	333	0	9,322	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	91	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,489	9,364	8,291	4,720	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,729	0	5,068	2,256	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	438	0	1,720	0	0	54.00
54.01	05401	ULTRASOUND	34	0	308	0	0	54.01
56.00	05600	RADIOISOTOPE	86	0	199	0	0	56.00
57.00	05700	CT SCAN	111	0	634	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	217	0	0	58.00
60.00	06000	LABORATORY	1,039	0	5,666	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	30	0	1,484	211	0	65.00
66.00	06600	PHYSICAL THERAPY	1,386	0	36	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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	39,347	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	45	0	0	0	0	75.01
75.02	03952	WOUND CENTER	35	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	331	0	525	0	0	76.00
76.01	03030	DIABETES EDUCATION	25	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,431	0	959	0	0	88.00
91.00	09100	EMERGENCY	2,025	0	2,914	3,253	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	166	0	72	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,195	38,436	42,593	10,440	39,347	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	1,907	0	344	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	20,102	38,436	42,937	10,440	39,347	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/21/2016 7:26 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	58,325					16.00
17.00	01700	SOCIAL SERVICE	0	1,200				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,193	1,200		221,667	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,489	0		300,203	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		2,594	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,661	0		166,451	0	54.00
54.01	05401	ULTRASOUND	511	0		47,262	0	54.01
56.00	05600	RADIOISOTOPE	296	0		13,481	0	56.00
57.00	05700	CT SCAN	753	0		126,328	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	457	0		236,119	0	58.00
60.00	06000	LABORATORY	3,467	0		101,812	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0		21,430	0	65.00
66.00	06600	PHYSICAL THERAPY	1,693	0		133,928	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		3,540	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		11,837	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		7,129	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		39,347	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	75.00
75.01	03951	SLEEP LAB	403	0		12,775	0	75.01
75.02	03952	WOUND CENTER	511	0		17,248	0	75.02
76.00	03953	CARDIAC REHAB	27	0		17,821	0	76.00
76.01	03030	DIABETES EDUCATION	0	0		4,166	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	30,424	0		502,095	0	88.00
91.00	09100	EMERGENCY	6,155	0		150,889	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0		43,623	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	56,040	1,200	0	2,181,745	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		2,954	0	190.00
194.00	07950	FREESTANDING CLINICS	2,285	0		111,976	0	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	58,325	1,200	0	2,296,675	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/21/2016 7:26 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	221,667		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	300,203		50.00
53.00	05300	ANESTHESIOLOGY	2,594		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	166,451		54.00
54.01	05401	ULTRASOUND	47,262		54.01
56.00	05600	RADIOISOTOPE	13,481		56.00
57.00	05700	CT SCAN	126,328		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	236,119		58.00
60.00	06000	LABORATORY	101,812		60.00
65.00	06500	RESPIRATORY THERAPY	21,430		65.00
66.00	06600	PHYSICAL THERAPY	133,928		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	3,540		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,837		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	7,129		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,347		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		75.00
75.01	03951	SLEEP LAB	12,775		75.01
75.02	03952	WOUND CENTER	17,248		75.02
76.00	03953	CARDIAC REHAB	17,821		76.00
76.01	03030	DIABETES EDUCATION	4,166		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	502,095		88.00
91.00	09100	EMERGENCY	150,889		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	43,623		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,181,745		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,954		190.00
194.00	07950	FREESTANDING CLINICS	111,976		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	2,296,675		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/21/2016 7:26 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	70,666					1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	0	27,343				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			1,178,062			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	12,713,809		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,789	5,537	256,071	2,708,693	-5,672,778	5.00
6.00	00600	MAINTENANCE & REPAIRS	3,350	0	487	195,294	0	6.00
7.00	00700	OPERATION OF PLANT	5,710	756	57,340	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	527	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	716	0	427	220,663	0	9.00
10.00	01000	DIETARY	1,648	0	6,993	185,338	0	10.00
11.00	01100	CAFETERIA	916	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	307	0	82	118,379	0	13.00
15.00	01500	PHARMACY	462	0	1,445	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,500	1,377	7,502	285,467	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	39,952	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,653	0	37,953	979,104	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,211	0	87,050	543,001	0	50.00
53.00	05300	ANESTHESIOLOGY	88	0	286	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,241	0	122,294	386,390	0	54.00
54.01	05401	ULTRASOUND	359	0	35,227	96,128	0	54.01
56.00	05600	RADIOISOTOPE	288	0	0	4,546	0	56.00
57.00	05700	CT SCAN	362	0	110,537	40,674	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	928	0	210,516	22,591	0	58.00
60.00	06000	LABORATORY	1,799	0	30,666	482,070	0	60.00
65.00	06500	RESPIRATORY THERAPY	183	0	5,237	48,185	0	65.00
66.00	06600	PHYSICAL THERAPY	481	11,421	22,781	594,885	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	174	0	0	33,280	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	571	0	439	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	568	0	1,199	0	0	75.01
75.02	03952	WOUND CENTER	1,485	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	899	0	5,015	86,877	0	76.00
76.01	03030	DIABETES EDUCATION	189	0	0	44,905	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,080	8,252	102,155	3,870,530	0	88.00
91.00	09100	EMERGENCY	2,982	0	53,836	675,280	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,641	0	6,858	578,816	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	63,107	27,343	1,162,396	12,241,048	-5,672,778	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	200	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	7,359	0	15,666	472,761	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	664,181	188,550	1,204,357	2,894,529		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.398876	6.895732	1.022321	0.227668		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/21/2016 7:26 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,355,936					5.00
6.00	00600	MAINTENANCE & REPAIRS	283,458	63,374				6.00
7.00	00700	OPERATION OF PLANT	565,697	5,710	29,353			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	51,190	527	527	10,117		8.00
9.00	00900	HOUSEKEEPING	415,290	716	716	0	153,491	9.00
10.00	01000	DIETARY	326,314	1,648	1,648	5	232	10.00
11.00	01100	CAFETERIA	8,609	916	916	0	2,580	11.00
13.00	01300	NURSING ADMINISTRATION	152,297	307	307	0	0	13.00
15.00	01500	PHARMACY	1,008,522	462	462	0	720	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	434,448	1,500	1,500	0	2,545	16.00
17.00	01700	SOCIAL SERVICE	49,817	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,433,313	6,653	6,653	3,297	26,637	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,270,824	6,211	6,211	1,590	20,840	50.00
53.00	05300	ANESTHESIOLOGY	45,851	88	88	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	808,642	1,241	1,241	505	3,343	54.00
54.01	05401	ULTRASOUND	214,936	359	359	444	260	54.01
56.00	05600	RADIOISOTOPE	386,574	288	288	121	659	56.00
57.00	05700	CT SCAN	274,493	362	362	514	850	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	289,089	928	928	330	0	58.00
60.00	06000	LABORATORY	1,532,281	1,799	1,799	0	7,930	60.00
65.00	06500	RESPIRATORY THERAPY	99,632	183	183	0	230	65.00
66.00	06600	PHYSICAL THERAPY	933,633	481	481	1,137	10,583	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	45,247	174	174	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	138,204	571	571	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	320,382	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	127,265	568	568	0	345	75.01
75.02	03952	WOUND CENTER	82,776	1,485	0	0	270	75.02
76.00	03953	CARDIAC REHAB	126,468	899	0	0	2,531	76.00
76.01	03030	DIABETES EDUCATION	62,463	189	189	0	190	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,541,845	16,927	0	166	41,456	88.00
91.00	09100	EMERGENCY	1,633,137	2,982	2,982	2,008	15,461	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	896,617	1,641	0	0	1,271	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,559,314	55,815	29,153	10,117	138,933	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,880	200	200	0	0	190.00
194.00	07950	FREESTANDING CLINICS	794,742	7,359	0	0	14,558	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,672,778	358,753	748,287	81,206	547,909	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.265630	5.660886	25.492692	8.026688	3.569649	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	475,226	38,536	133,607	8,811	20,102	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.022253	0.608073	4.551732	0.870910	0.130965	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/21/2016 7:26 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			10.00	11.00	13.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	25,375					10.00
11.00	01100	CAFETERIA	19,193	2,372				11.00
13.00	01300	NURSING ADMINISTRATION	0	138	94,415			13.00
15.00	01500	PHARMACY	0	143	0	1,594,442		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	515	0	0	2,170	16.00
17.00	01700	SOCIAL SERVICE	0	5	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,182	458	42,684	0	156	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	280	20,398	0	167	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	95	0	0	99	54.00
54.01	05401	ULTRASOUND	0	17	0	0	19	54.01
56.00	05600	RADIOISOTOPE	0	11	0	0	11	56.00
57.00	05700	CT SCAN	0	35	0	0	28	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	12	0	0	17	58.00
60.00	06000	LABORATORY	0	313	0	0	129	60.00
65.00	06500	RESPIRATORY THERAPY	0	82	1,910	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2	0	0	63	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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,594,442	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	0	0	0	15	75.01
75.02	03952	WOUND CENTER	0	0	0	0	19	75.02
76.00	03953	CARDIAC REHAB	0	29	0	0	1	76.00
76.01	03030	DIABETES EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	53	0	0	1,132	88.00
91.00	09100	EMERGENCY	0	161	29,423	0	229	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	4	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	25,375	2,353	94,415	1,594,442	2,085	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	0	19	0	0	85	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	465,202	400,509	225,617	1,317,524	692,621	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.333084	168.848651	2.389631	0.826323	319.180184	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	38,436	42,937	10,440	39,347	58,325	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.514719	18.101602	0.110576	0.024678	26.877880	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/21/2016 7:26 pm

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			17.00	19.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	863			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	863	0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		75.00
75.01	03951	SLEEP LAB	0	0		75.01
75.02	03952	WOUND CENTER	0	0		75.02
76.00	03953	CARDIAC REHAB	0	0		76.00
76.01	03030	DIABETES EDUCATION	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	863	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
194.00	07950	FREESTANDING CLINICS	0	0		194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	63,894	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	74.037080	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,200	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.390498	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/21/2016 7:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,549,213		2,549,213	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,038,366		2,038,366	0	0	50.00
53.00	05300	ANESTHESIOLOGY	60,771		60,771	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,125,729		1,125,729	0	0	54.00
54.01	05401	ULTRASOUND	296,639		296,639	0	0	54.01
56.00	05600	RADIOISOTOPE	506,923		506,923	0	0	56.00
57.00	05700	CT SCAN	380,691		380,691	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	404,891		404,891	0	0	58.00
60.00	06000	LABORATORY	2,117,677		2,117,677	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	151,029	0	151,029	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,263,969	0	1,263,969	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	62,687		62,687	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	192,703		192,703	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	405,485		405,485	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,317,524		1,317,524	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	75.00
75.01	03951	SLEEP LAB	184,785		184,785	0	0	75.01
75.02	03952	WOUND CENTER	120,198		120,198	0	0	75.02
76.00	03953	CARDIAC REHAB	179,402		179,402	0	0	76.00
76.01	03030	DIABETES EDUCATION	85,621		85,621	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,894,960		8,894,960	0	0	88.00
91.00	09100	EMERGENCY	2,401,742		2,401,742	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	708,896		708,896		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,149,287		1,149,287		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	26,599,188	0	26,599,188	0	0	200.00
201.00		Less Observation Beds	708,896		708,896		0	201.00
202.00		Total (see instructions)	25,890,292	0	25,890,292	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/21/2016 7:26 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	813,928		813,928			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	298,724	4,507,996	4,806,720	0.424066	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	19,647	125,028	144,675	0.420052	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	43,323	2,784,164	2,827,487	0.398138	0.000000	54.00
54.01	05401	ULTRASOUND	152,368	3,177,597	3,329,965	0.089082	0.000000	54.01
56.00	05600	RADIOISOTOPE	26,871	1,699,845	1,726,716	0.293576	0.000000	56.00
57.00	05700	CT SCAN	143,596	9,866,938	10,010,534	0.038029	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	19,404	2,706,383	2,725,787	0.148541	0.000000	58.00
60.00	06000	LABORATORY	370,006	9,931,979	10,301,985	0.205560	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	68,315	273,121	341,436	0.442335	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	454,866	4,417,053	4,871,919	0.259440	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	13,650	448,316	461,966	0.135696	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	149,826	919,586	1,069,412	0.180195	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	244,462	398,856	643,318	0.630303	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	328,174	1,971,334	2,299,508	0.572959	0.000000	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	75.00
75.01	03951	SLEEP LAB	0	676,252	676,252	0.273249	0.000000	75.01
75.02	03952	WOUND CENTER	0	275,755	275,755	0.435887	0.000000	75.02
76.00	03953	CARDIAC REHAB	0	201,454	201,454	0.890536	0.000000	76.00
76.01	03030	DIABETES EDUCATION	0	25,192	25,192	3.398738	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,594,538	6,594,538			88.00
91.00	09100	EMERGENCY	51,175	6,620,438	6,671,613	0.359994	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,050	348,253	353,303	2.006482	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,774,214	1,774,214			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	3,203,385	59,744,292	62,947,677			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,203,385	59,744,292	62,947,677			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/21/2016 7:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	75.00
75.01	03951	SLEEP LAB	0.000000	75.01
75.02	03952	WOUND CENTER	0.000000	75.02
76.00	03953	CARDIAC REHAB	0.000000	76.00
76.01	03030	DIABETES EDUCATION	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
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: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/21/2016 7:26 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	300,203	4,806,720	0.062455	171,326	10,700	50.00
53.00	05300	ANESTHESIOLOGY	2,594	144,675	0.017930	10,129	182	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	166,451	2,827,487	0.058869	23,727	1,397	54.00
54.01	05401	ULTRASOUND	47,262	3,329,965	0.014193	98,126	1,393	54.01
56.00	05600	RADIOISOTOPE	13,481	1,726,716	0.007807	13,571	106	56.00
57.00	05700	CT SCAN	126,328	10,010,534	0.012620	77,899	983	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	236,119	2,725,787	0.086624	9,582	830	58.00
60.00	06000	LABORATORY	101,812	10,301,985	0.009883	234,156	2,314	60.00
65.00	06500	RESPIRATORY THERAPY	21,430	341,436	0.062764	32,437	2,036	65.00
66.00	06600	PHYSICAL THERAPY	133,928	4,871,919	0.027490	96,607	2,656	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,540	461,966	0.007663	8,400	64	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,837	1,069,412	0.011069	80,064	886	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	7,129	643,318	0.011082	175,774	1,948	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,347	2,299,508	0.017111	150,230	2,571	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	75.00
75.01	03951	SLEEP LAB	12,775	676,252	0.018891	0	0	75.01
75.02	03952	WOUND CENTER	17,248	275,755	0.062548	0	0	75.02
76.00	03953	CARDIAC REHAB	17,821	201,454	0.088462	0	0	76.00
76.01	03030	DIABETES EDUCATION	4,166	25,192	0.165370	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	502,095	6,594,538	0.076138	0	0	88.00
91.00	09100	EMERGENCY	150,889	6,671,613	0.022617	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	61,642	353,303	0.174473	601	105	92.00
200.00		Total (lines 50-199)	1,978,097	60,359,535		1,182,629	28,171	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/21/2016 7:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	0	0	0	0	75.01
75.02	03952	WOUND CENTER	0	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	DIABETES EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/21/2016 7:26 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	4,806,720	0.000000	0.000000	171,326	50.00
53.00	05300	ANESTHESIOLOGY	0	144,675	0.000000	0.000000	10,129	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	2,827,487	0.000000	0.000000	23,727	54.00
54.01	05401	ULTRASOUND	0	3,329,965	0.000000	0.000000	98,126	54.01
56.00	05600	RADIOISOTOPE	0	1,726,716	0.000000	0.000000	13,571	56.00
57.00	05700	CT SCAN	0	10,010,534	0.000000	0.000000	77,899	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,725,787	0.000000	0.000000	9,582	58.00
60.00	06000	LABORATORY	0	10,301,985	0.000000	0.000000	234,156	60.00
65.00	06500	RESPIRATORY THERAPY	0	341,436	0.000000	0.000000	32,437	65.00
66.00	06600	PHYSICAL THERAPY	0	4,871,919	0.000000	0.000000	96,607	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	461,966	0.000000	0.000000	8,400	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,069,412	0.000000	0.000000	80,064	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	643,318	0.000000	0.000000	175,774	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,299,508	0.000000	0.000000	150,230	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	75.00
75.01	03951	SLEEP LAB	0	676,252	0.000000	0.000000	0	75.01
75.02	03952	WOUND CENTER	0	275,755	0.000000	0.000000	0	75.02
76.00	03953	CARDIAC REHAB	0	201,454	0.000000	0.000000	0	76.00
76.01	03030	DIABETES EDUCATION	0	25,192	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,594,538	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	6,671,613	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	353,303	0.000000	0.000000	601	92.00
200.00		Total (lines 50-199)	0	60,359,535			1,182,629	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/21/2016 7:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		75.00
75.01	03951	SLEEP LAB	0	0	0		75.01
75.02	03952	WOUND CENTER	0	0	0		75.02
76.00	03953	CARDIAC REHAB	0	0	0		76.00
76.01	03030	DIABETES EDUCATION	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/21/2016 7:26 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	0.424066	0	1,656,681	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.420052	0	28,556	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.398138	0	1,032,061	0	0	54.00
54.01	05401	ULTRASOUND	0.089082	0	1,178,897	0	0	54.01
56.00	05600	RADIOISOTOPE	0.293576	0	774,744	0	0	56.00
57.00	05700	CT SCAN	0.038029	0	3,511,512	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.148541	0	853,434	0	0	58.00
60.00	06000	LABORATORY	0.205560	0	3,763,963	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.442335	0	120,177	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.259440	0	1,636,250	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.135696	0	192,819	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.180195	0	285,368	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.630303	0	102,834	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.572959	0	1,579,897	326	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0.273249	0	198,061	0	0	75.01
75.02	03952	WOUND CENTER	0.435887	0	125,845	0	0	75.02
76.00	03953	CARDIAC REHAB	0.890536	0	116,108	0	0	76.00
76.01	03030	DIABETES EDUCATION	3.398738	0	9,193	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.359994	0	1,395,611	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.006482	0	172,079	0	0	92.00
200.00		Subtotal (see instructions)		0	18,734,090	326	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	18,734,090	326	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/21/2016 7:26 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	702,542	0		50.00
53.00	05300	ANESTHESIOLOGY	11,995	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	410,903	0		54.00
54.01	05401	ULTRASOUND	105,019	0		54.01
56.00	05600	RADIOISOTOPE	227,446	0		56.00
57.00	05700	CT SCAN	133,539	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	126,770	0		58.00
60.00	06000	LABORATORY	773,720	0		60.00
65.00	06500	RESPIRATORY THERAPY	53,158	0		65.00
66.00	06600	PHYSICAL THERAPY	424,509	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	26,165	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,422	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	64,817	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	905,216	187		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		75.00
75.01	03951	SLEEP LAB	54,120	0		75.01
75.02	03952	WOUND CENTER	54,854	0		75.02
76.00	03953	CARDIAC REHAB	103,398	0		76.00
76.01	03030	DIABETES EDUCATION	31,245	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	502,412	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	345,273	0		92.00
200.00		Subtotal (see instructions)	5,108,523	187		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,108,523	187		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141349 | Component CCN: 14Z349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/21/2016 7:26 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	0.424066	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.420052	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.398138	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.089082	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.293576	0	0	0	0	56.00
57.00	05700	CT SCAN	0.038029	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.148541	0	0	0	0	58.00
60.00	06000	LABORATORY	0.205560	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.442335	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.259440	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.135696	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.180195	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.630303	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.572959	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0.273249	0	0	0	0	75.01
75.02	03952	WOUND CENTER	0.435887	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	0.890536	0	0	0	0	76.00
76.01	03030	DIABETES EDUCATION	3.398738	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.359994	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.006482	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: 141349 | Component CCN: 14Z349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/21/2016 7:26 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		75.00
75.01	03951	SLEEP LAB	0	0		75.01
75.02	03952	WOUND CENTER	0	0		75.02
76.00	03953	CARDIAC REHAB	0	0		76.00
76.01	03030	DIABETES EDUCATION	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/21/2016 7:26 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)	2,171	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,416	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)	863	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	274	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)	275	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	103	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)	103	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	626	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)	274	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)	275	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	143.61	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	150.15	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,549,213	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)	14,792	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)	15,465	25.00
26.00	Total swing-bed cost (see instructions)	734,026	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,815,187	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)	1,815,187	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)	1,281.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	802,476	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)	802,476	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/21/2016 7:26 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	404,651	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,207,127	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)	351,243	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	352,525	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	703,768	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)	553	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,281.91	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	708,896	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/21/2016 7:26 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	221,667	2,549,213	0.086955	708,896	61,642	90.00
91.00	Nursing School cost	0	2,549,213	0.000000	708,896	0	91.00
92.00	Allied health cost	0	2,549,213	0.000000	708,896	0	92.00
93.00	All other Medical Education	0	2,549,213	0.000000	708,896	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/21/2016 7:26 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		313,000		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.424066	171,326	72,654	50.00
53.00	05300	ANESTHESIOLOGY	0.420052	10,129	4,255	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.398138	23,727	9,447	54.00
54.01	05401	ULTRASOUND	0.089082	98,126	8,741	54.01
56.00	05600	RADIOISOTOPE	0.293576	13,571	3,984	56.00
57.00	05700	CT SCAN	0.038029	77,899	2,962	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.148541	9,582	1,423	58.00
60.00	06000	LABORATORY	0.205560	234,156	48,133	60.00
65.00	06500	RESPIRATORY THERAPY	0.442335	32,437	14,348	65.00
66.00	06600	PHYSICAL THERAPY	0.259440	96,607	25,064	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.135696	8,400	1,140	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.180195	80,064	14,427	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.630303	175,774	110,791	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.572959	150,230	86,076	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	75.00
75.01	03951	SLEEP LAB	0.273249	0	0	75.01
75.02	03952	WOUND CENTER	0.435887	0	0	75.02
76.00	03953	CARDIAC REHAB	0.890536	0	0	76.00
76.01	03030	DIABETES EDUCATION	3.398738	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.359994	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.006482	601	1,206	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,182,629	404,651	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,182,629		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141349 | Component CCN: 14Z349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/21/2016 7:26 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.424066	964	409	50.00
53.00	05300	ANESTHESIOLOGY	0.420052	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.398138	3,584	1,427	54.00
54.01	05401	ULTRASOUND	0.089082	9,196	819	54.01
56.00	05600	RADIOISOTOPE	0.293576	0	0	56.00
57.00	05700	CT SCAN	0.038029	7,253	276	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.148541	0	0	58.00
60.00	06000	LABORATORY	0.205560	36,933	7,592	60.00
65.00	06500	RESPIRATORY THERAPY	0.442335	15,217	6,731	65.00
66.00	06600	PHYSICAL THERAPY	0.259440	233,053	60,463	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.135696	788	107	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.180195	8,440	1,521	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.630303	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.572959	80,159	45,928	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	75.00
75.01	03951	SLEEP LAB	0.273249	0	0	75.01
75.02	03952	WOUND CENTER	0.435887	0	0	75.02
76.00	03953	CARDIAC REHAB	0.890536	0	0	76.00
76.01	03030	DIABETES EDUCATION	3.398738	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.359994	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.006482	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		395,587	125,273	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)		395,587		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141349	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/21/2016 7:26 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,108,710	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)	5,108,710	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)	5,159,797	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)	35,727	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,982,134	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)	2,141,936	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)	2,141,936	30.00
31.00	Primary payer payments	1,156	31.00
32.00	Subtotal (line 30 minus line 31)	2,140,780	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)	365,678	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	237,691	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	237,218	36.00
37.00	Subtotal (see instructions)	2,378,471	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)	2,378,471	40.00
40.01	Sequestration adjustment (see instructions)	47,569	40.01
41.00	Interim payments	2,506,110	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-175,208	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I Date/Time Prepared: 11/21/2016 7:26 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		908,244		2,702,457	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	01/28/2016	34,191		0	3.01
3.02		06/16/2016	36,471		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	01/28/2016	156,361	3.50
3.51			0	06/16/2016	39,986	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)		70,662		-196,347	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)		978,906		2,506,110	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		48,796		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		175,208	6.02
7.00	Total Medicare program liability (see instructions)		1,027,702		2,330,902	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: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2016 7:26 pm

Component CCN: 14Z349 | 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		677,310		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	01/28/2016	39,234		0	3.01
3.02		06/16/2016	30,975		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)		70,209		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)		747,519		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		64,220		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		811,739		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141349	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/21/2016 7:26 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	344	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	626	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	28	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	863	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	62,947,677	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	63,830	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: 141349 Component CCN: 14Z349	Period: From 07/01/2015 To 06/30/2016	Worksheet E-2 Date/Time Prepared: 11/21/2016 7:26 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)	710,806	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)	126,526	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	549	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	837,332	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	837,332	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	837,332	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	9,027	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)	828,305	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)	828,305	0	19.00
19.01	Sequestration adjustment (see instructions)	16,566	0	19.01
20.00	Interim payments	747,519	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)	64,220	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: 141349	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part V Date/Time Prepared: 11/21/2016 7:26 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,207,127	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,207,127	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,219,198	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,219,198	19.00
20.00	Deductibles (exclude professional component)	196,243	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,022,955	22.00
23.00	Coinsurance	8,974	23.00
24.00	Subtotal (line 22 minus line 23)	1,013,981	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	53,377	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	34,695	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	34,625	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,048,676	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	1,048,676	30.00
30.01	Sequestration adjustment (see instructions)	20,974	30.01
31.00	Interim payments	978,906	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)	48,796	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G | Date/Time Prepared: 11/21/2016 7:26 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	7,644,739	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	16,665,498	0	0	0	4.00
5.00	Other receivable	207,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,781,298	0	0	0	6.00
7.00	Inventory	568,893	0	0	0	7.00
8.00	Prepaid expenses	840,310	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	48,213	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	15,193,355	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	236,334	0	0	0	12.00
13.00	Land improvements	845,711	0	0	0	13.00
14.00	Accumulated depreciation	-640,335	0	0	0	14.00
15.00	Buildings	16,710,703	0	0	0	15.00
16.00	Accumulated depreciation	-12,005,113	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	23,015	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	14,128,110	0	0	0	23.00
24.00	Accumulated depreciation	-9,930,126	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	74,835	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	9,443,134	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,289,419	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,289,419	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	26,925,908	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	567,721	0	0	0	37.00
38.00	Salaries, wages, and fees payable	878,313	0	0	0	38.00
39.00	Payroll taxes payable	872,699	0	0	0	39.00
40.00	Notes and loans payable (short term)	455,817	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,774,550	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,834,441	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,834,441	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,608,991	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	21,316,917				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)	21,316,917	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	26,925,908	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-1 | Date/Time Prepared: 11/21/2016 7:26 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		20,454,816		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		862,101				2.00
3.00	Total (sum of line 1 and line 2)		21,316,917		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		21,316,917		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)		21,316,917		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/21/2016 7:26 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	624,000		624,000	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	116,060		116,060	5.00
6.00	Swing bed - NF	21,420		21,420	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	761,480		761,480	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)	761,480		761,480	17.00
18.00	Ancillary services	2,334,541	45,070,434	47,404,975	18.00
19.00	Outpatient services	-44,210	7,184,260	7,140,050	19.00
20.00	RURAL HEALTH CLINIC	0	6,766,943	6,766,943	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,774,214	1,774,214	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	37,483	677,748	715,231	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,089,294	61,473,599	64,562,893	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		30,550,849		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)		30,550,849		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-3 | Date/Time Prepared: 11/21/2016 7:26 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	64,562,893	1.00
2.00	Less contractual allowances and discounts on patients' accounts	35,730,348	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,832,545	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	30,550,849	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,718,304	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	266,251	6.00
7.00	Income from investments	58,843	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	41,373	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	2,917	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	149,744	22.00
23.00	Governmental appropriations	249,241	23.00
24.00	OTHER MISC REVENUES	575,246	24.00
24.01	340B CONTRACT PHARMACY REVENUE	1,236,790	24.01
25.00	Total other income (sum of lines 6-24)	2,580,405	25.00
26.00	Total (line 5 plus line 25)	862,101	26.00
27.00	GAIN AND LOSS ON IMPAIRMENT	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	862,101	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141349 | HHA CCN: 147694 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H | Date/Time Prepared: 11/21/2016 7:26 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	19,511	19,511	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	250,948	0	0	0	122,709	373,657	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	212,161	0	0	0	0	212,161	6.00
7.00	Physical Therapy	115,343	0	0	270	0	115,613	7.00
8.00	Occupational Therapy	0	0	0	15,454	0	15,454	8.00
9.00	Speech Pathology	0	0	0	5,584	0	5,584	9.00
10.00	Medical Social Services	0	0	0	60	0	60	10.00
11.00	Home Health Aide	364	0	0	0	0	364	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	578,816	0	0	21,368	142,220	742,404	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	19,511	0	19,511			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	373,657	0	373,657			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	212,161	0	212,161			6.00
7.00	Physical Therapy	0	115,613	0	115,613			7.00
8.00	Occupational Therapy	0	15,454	0	15,454			8.00
9.00	Speech Pathology	0	5,584	0	5,584			9.00
10.00	Medical Social Services	0	60	0	60			10.00
11.00	Home Health Aide	0	364	0	364			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	0	742,404	0	742,404			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: 141349 | HHA CCN: 147694 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H-1 Part I | Date/Time Prepared: 11/21/2016 7:26 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	19,511	0	0	19,511		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	373,657	0	0	19,511	0	393,168	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	212,161	0	0	0	0	212,161	6.00
7.00	Physical Therapy	115,613	0	0	0	0	115,613	7.00
8.00	Occupational Therapy	15,454	0	0	0	0	15,454	8.00
9.00	Speech Pathology	5,584	0	0	0	0	5,584	9.00
10.00	Medical Social Services	60	0	0	0	0	60	10.00
11.00	Home Health Aide	364	0	0	0	0	364	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	742,404	0	0	19,511	0	742,404	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	393,168		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	238,849	451,010	6.00
7.00	Physical Therapy	130,157	245,770	7.00
8.00	Occupational Therapy	17,398	32,852	8.00
9.00	Speech Pathology	6,286	11,870	9.00
10.00	Medical Social Services	68	128	10.00
11.00	Home Health Aide	410	774	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		742,404	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 141349 HHA CCN: 147694 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H-1 Part II Date/Time Prepared: 11/21/2016 7:26 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	1,641		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	1,641	0	-393,168	349,236	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	212,161	6.00
7.00	Physical Therapy	0	0	0	0	0	115,613	7.00
8.00	Occupational Therapy	0	0	0	0	0	15,454	8.00
9.00	Speech Pathology	0	0	0	0	0	5,584	9.00
10.00	Medical Social Services	0	0	0	0	0	60	10.00
11.00	Home Health Aide	0	0	0	0	0	364	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	1,641	0	-393,168	349,236	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	19,511	0		393,168	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	11.889701	0.000000		1.125795	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141349 HHA CCN: 147694 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H-2 Part I Date/Time Prepared: 11/21/2016 7:26 pm

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS NORTH CAMPUS BLDG	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	1.01	2.00	4.00	4A	
1.00	Administrative and General	0	15,424	0	7,011	57,133	79,568	1.00
2.00	Skilled Nursing Care	451,010	0	0	0	48,302	499,312	2.00
3.00	Physical Therapy	245,770	0	0	0	26,260	272,030	3.00
4.00	Occupational Therapy	32,852	0	0	0	0	32,852	4.00
5.00	Speech Pathology	11,870	0	0	0	0	11,870	5.00
6.00	Medical Social Services	128	0	0	0	0	128	6.00
7.00	Home Health Aide	774	0	0	0	83	857	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)	742,404	15,424	0	7,011	131,778	896,617	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.000000	21.00

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	21,136	9,290	0	0	4,537	0	1.00
2.00	Skilled Nursing Care	132,632	0	0	0	0	0	2.00
3.00	Physical Therapy	72,259	0	0	0	0	0	3.00
4.00	Occupational Therapy	8,726	0	0	0	0	0	4.00
5.00	Speech Pathology	3,153	0	0	0	0	0	5.00
6.00	Medical Social Services	34	0	0	0	0	0	6.00
7.00	Home Health Aide	228	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)	238,168	9,290	0	0	4,537	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141349 | HHA CCN: 147694 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H-2 Part I | Date/Time Prepared: 11/21/2016 7:26 pm

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	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
		11.00	13.00	15.00	16.00	17.00	19.00	
1.00	Administrative and General	675	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)	675	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	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	115,206	0	115,206				1.00
2.00	Skilled Nursing Care	631,944	0	631,944	70,404	702,348		2.00
3.00	Physical Therapy	344,289	0	344,289	38,357	382,646		3.00
4.00	Occupational Therapy	41,578	0	41,578	4,632	46,210		4.00
5.00	Speech Pathology	15,023	0	15,023	1,674	16,697		5.00
6.00	Medical Social Services	162	0	162	18	180		6.00
7.00	Home Health Aide	1,085	0	1,085	121	1,206		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
20.00	Total (sum of lines 1-19) (2)	1,149,287	0	1,149,287	115,206	1,149,287		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.				0.111409			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: 141349 HHA CCN: 147694

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

Worksheet H-2 Part II Date/Time Prepared: 11/21/2016 7:26 pm

Home Health Agency I

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	1.01	2.00	4.00	5A	5.00	
1.00	Administrative and General	1,641	0	6,858	250,948	0	79,568	1.00
2.00	Skilled Nursing Care	0	0	0	212,161	0	499,312	2.00
3.00	Physical Therapy	0	0	0	115,343	0	272,030	3.00
4.00	Occupational Therapy	0	0	0	0	0	32,852	4.00
5.00	Speech Pathology	0	0	0	0	0	11,870	5.00
6.00	Medical Social Services	0	0	0	0	0	128	6.00
7.00	Home Health Aide	0	0	0	364	0	857	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)	1,641	0	6,858	578,816		896,617	20.00
21.00	Total cost to be allocated	15,424	0	7,011	131,778		238,168	21.00
22.00	Unit cost multiplier	9.399147	0.000000	1.022310	0.227668		0.265630	22.00

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	1,641	0	0	1,271	0	4	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)	1,641	0	0	1,271	0	4	20.00
21.00	Total cost to be allocated	9,290	0	0	4,537	0	675	21.00
22.00	Unit cost multiplier	5.661182	0.000000	0.000000	3.569630	0.000000	168.750000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141349 | HHA CCN: 147694 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H-2 Part II | Date/Time Prepared: 11/21/2016 7:26 pm

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141349 | HHA CCN: 147694 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H-3 Part I | Date/Time Prepared: 11/21/2016 7:26 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	702,348		702,348	4,102	171.22	1.00
2.00	Physical Therapy	3.00	382,646	0	382,646	3,474	110.15	2.00
3.00	Occupational Therapy	4.00	46,210	0	46,210	117	394.96	3.00
4.00	Speech Pathology	5.00	16,697	0	16,697	91	183.48	4.00
5.00	Medical Social Services	6.00	180		180	1	180.00	5.00
6.00	Home Health Aide	7.00	1,206		1,206	11	109.64	6.00
7.00	Total (sum of lines 1-6)		1,149,287	0	1,149,287	7,796		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	1,689			8.00
8.01	Skilled Nursing Care		41180	0	156			8.01
8.02	Skilled Nursing Care		16060	0	70			8.02
9.00	Physical Therapy		99914	0	1,724			9.00
9.01	Physical Therapy		41180	0	193			9.01
9.02	Physical Therapy		16060	0	100			9.02
10.00	Occupational Therapy		99914	0	49			10.00
10.01	Occupational Therapy		41180	0	17			10.01
10.02	Occupational Therapy		16060	0	0			10.02
11.00	Speech Pathology		99914	0	26			11.00
11.01	Speech Pathology		41180	0	1			11.01
11.02	Speech Pathology		16060	0	0			11.02
12.00	Medical Social Services		99914	0	1			12.00
12.01	Medical Social Services		41180	0	0			12.01
12.02	Medical Social Services		16060	0	0			12.02
13.00	Home Health Aide		99914	0	8			13.00
13.01	Home Health Aide		41180	0	0			13.01
13.02	Home Health Aide		16060	0	0			13.02
14.00	Total (sum of lines 8-13)			0	4,034			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	3,329	3,329	18,475	0.180189	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,915		0	327,886		1.00
2.00	Physical Therapy	0	2,017		0	222,173		2.00
3.00	Occupational Therapy	0	66		0	26,067		3.00
4.00	Speech Pathology	0	27		0	4,954		4.00
5.00	Medical Social Services	0	1		0	180		5.00
6.00	Home Health Aide	0	8		0	877		6.00
7.00	Total (sum of lines 1-6)	0	4,034		0	582,137		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H-3 Part I
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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
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
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	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	327,886	1.00
2.00	Physical Therapy	222,173	2.00
3.00	Occupational Therapy	26,067	3.00
4.00	Speech Pathology	4,954	4.00
5.00	Medical Social Services	180	5.00
6.00	Home Health Aide	877	6.00
7.00	Total (sum of lines 1-6)	582,137	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
8.02	Skilled Nursing Care		8.02
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
9.02	Physical Therapy		9.02
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
10.02	Occupational Therapy		10.02
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
11.02	Speech Pathology		11.02
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
12.02	Medical Social Services		12.02
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
13.02	Home Health Aide		13.02
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H-3 Part II | Date/Time Prepared: 11/21/2016 7:26 pm

HHA CCN: 147694 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.259440	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.000000	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.000000	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.180195	18,475	3,329	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.572959	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H-4 Part I-II

HHA CCN: 147694 | Date/Time Prepared: 11/21/2016 7:26 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	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	688,494	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	4,989	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	7,571	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	9,639	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	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	710,693	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	710,693	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	710,693	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	710,693	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	710,693	31.00
31.01	Sequestration adjustment (see instructions)	0	0	31.01
32.00	Interim payments (see instructions)	0	710,693	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: 141349 HHA CCN: 147694 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H-5 Date/Time Prepared: 11/21/2016 7:26 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		710,693	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		710,693	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		710,693	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

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

Provider CCN: 141349 Component CCN: 143464 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-1 | Date/Time Prepared: 11/21/2016 7:26 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,630,737	618,361	2,249,098	0	2,249,098	1.00
2.00	Physician Assistant	307,086	0	307,086	0	307,086	2.00
3.00	Nurse Practitioner	504,163	38,975	543,138	0	543,138	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,029,738	0	1,029,738	0	1,029,738	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	15,678	15,678	0	15,678	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	3,471,724	673,014	4,144,738	0	4,144,738	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	435,943	435,943	0	435,943	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	104,829	104,829	0	104,829	18.00
19.00	Other Health Care Costs	0	25,071	25,071	0	25,071	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	565,843	565,843	0	565,843	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,471,724	1,238,857	4,710,581	0	4,710,581	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	2,553	2,553	0	2,553	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	2,553	2,553	0	2,553	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	94,515	94,515	0	94,515	29.00
30.00	Administrative Costs	398,806	176,068	574,874	47,226	622,100	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	398,806	270,583	669,389	47,226	716,615	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,870,530	1,511,993	5,382,523	47,226	5,429,749	32.00

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

Provider CCN: 141349 | Component CCN: 143464 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-1 | Date/Time Prepared: 11/21/2016 7:26 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-62,777	2,186,321		1.00
2.00	Physician Assistant	0	307,086		2.00
3.00	Nurse Practitioner	0	543,138		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	1,029,738		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	15,678		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-62,777	4,081,961		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	435,943		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	104,829		18.00
19.00	Other Health Care Costs	0	25,071		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	565,843		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-62,777	4,647,804		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	2,553		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	2,553		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	94,515		29.00
30.00	Administrative Costs	0	622,100		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	716,615		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-62,777	5,366,972		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141349 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-2

Component CCN: 143464 | Date/Time Prepared: 11/21/2016 7:26 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	6.98	22,998	4,200	29,316		1.00
2.00	Physician Assistant	2.76	7,404	2,100	5,796		2.00
3.00	Nurse Practitioner	5.27	15,582	2,100	11,067		3.00
4.00	Subtotal (sum of lines 1 through 3)	15.01	45,984		46,179	46,179	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.18	202			202	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	15.19	46,186			46,381	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	4,647,804	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	2,553	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	4,650,357	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)	0.999451	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)	716,615	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	3,527,988	15.00
16.00	Total overhead (sum of lines 14 and 15)	4,244,603	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtotal (see instructions)	4,244,603	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	4,242,273	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	8,890,077	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141349 | Component CCN: 143464 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-3 | Date/Time Prepared: 11/21/2016 7:26 pm

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		8,890,077	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		404,980	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		8,485,097	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		46,381	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		46,381	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		182.94	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions)	182.94	182.94	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	5,967	5,967	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	1,091,603	1,091,603	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		2,183,206	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,427,359	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		46,294	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		70,808	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,566,470	16.04
16.05	Total program cost (see instructions)		1,637,278	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		154,311	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		245,351	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,637,278	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		153,203	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,790,481	22.00
23.00	Allowable bad debts (see instructions)		31,805	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		20,673	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		31,422	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		1,811,154	26.00
26.01	Sequestration adjustment (see instructions)		36,223	26.01
27.00	Interim payments		1,500,510	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		274,421	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141349 | Component CCN: 143464 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-4 | Date/Time Prepared: 11/21/2016 7:26 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	4,081,961	4,081,961	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000879	0.001413	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	3,588	5,768	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	167,443	34,873	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	171,031	40,641	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	4,647,804	4,647,804	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	4,244,603	4,244,603	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.036798	0.008744	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	156,193	37,115	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	327,224	77,756	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	1,065	1,713	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	307.25	45.39	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	419	539	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	128,738	24,465	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		404,980	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		153,203	16.00

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

Provider CCN: 141349 Component CCN: 143464 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-5 | Date/Time Prepared: 11/21/2016 7:26 pm

Rural Health Clinic (RHC) I | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		1,487,482	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		01/28/2016	13,028	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		13,028	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,500,510	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		274,421	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,774,931	7.00

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