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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1349	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/15/2017 10:47 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/15/2017 Time: 10:47 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SPARTA COMMUNITY HOSPITAL (14-1349) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 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	75,897	-332,495	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	65,324	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		407,660		0	10.00
200.00	Total	0	141,221	75,165	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: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/15/2017 10:44 am

	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)	07/01/2016	06/30/2017	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1349	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/15/2017 10:44 am

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1349	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/15/2017 10:44 am

		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: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/15/2017 10:44 am

		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:	428,256	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: 14-1349	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/15/2017 10:44 am

		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	N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1349	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/15/2017 10:44 am

		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)	07/01/2016	09/30/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

		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	09/26/2017	Y	09/26/2017	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: 14-1349	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/15/2017 10:44 am

		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.	PATRICIA	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: 14-1349	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/15/2017 10:44 am

		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: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/15/2017 10:44 am

	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	9,125	22,645.00	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	9,125	22,645.00	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	9,125	22,645.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/15/2017 10:44 am

	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)	653	88	953			1.00
2.00	HMO and other (see instructions)	73	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	479	0	610			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	5			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,132	88	1,568			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)	1,132	88	1,568	0.00	179.55	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	5,023	0	7,732	0.00	10.39	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	14			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	13,122	0	49,502	0.00	68.51	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	258.45	27.00
28.00	Observation Bed Days		35	360			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			7			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/15/2017 10:44 am

	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	252	34	372	1.00
2.00	HMO and other (see instructions)			21	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	252	34	372	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	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 14-1349 | Component CCN: 14-7694 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-4 | Date/Time Prepared: 11/15/2017 10:44 am

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	286.00	48.00	155.00	489.00	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		3.53	0.00	3.53	5.00
6.00	Direct Nursing Service		4.16	0.00	4.16	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		2.44	0.00	2.44	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.20	0.20	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.15	0.15	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		0.02	0.00	0.02	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	Full Episodes With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	2,057	50	28	63	2,198	21.00
22.00	Skilled Nursing Visit Charges	583,927	13,693	8,681	18,327	624,628	22.00
23.00	Physical Therapy Visits	2,470	31	15	60	2,576	23.00
24.00	Physical Therapy Visit Charges	558,375	6,938	4,373	14,432	584,118	24.00
25.00	Occupational Therapy Visits	104	25	0	1	130	25.00
26.00	Occupational Therapy Visit Charges	23,448	5,562	0	0	29,010	26.00
27.00	Speech Pathology Visits	103	0	0	7	110	27.00
28.00	Speech Pathology Visit Charges	28,264	0	0	1,976	30,240	28.00
29.00	Medical Social Service Visits	1	0	0	0	1	29.00
30.00	Medical Social Service Visit Charges	410	0	0	0	410	30.00
31.00	Home Health Aide Visits	8	0	0	0	8	31.00
32.00	Home Health Aide Visit Charges	1,248	0	0	0	1,248	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,743	106	43	131	5,023	33.00
34.00	Other Charges	14,164	123	186	336	14,809	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,209,836	26,316	13,240	35,071	1,284,463	35.00
36.00	Total Number of Episodes (standard/non outlier)	308		13	13	334	36.00
37.00	Total Number of Outlier Episodes		3		0	3	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1349 | Component CCN: 14-3464 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-8 | Date/Time Prepared: 11/15/2017 10:44 am

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

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

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic	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	RHC/FQHC 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 RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-8

Component CCN: 14-3464 | Date/Time Prepared: 11/15/2017 10:44 am

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: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-10 | Date/Time Prepared: 11/15/2017 10:44 am

		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)	0.414354	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,891,044	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	2,768,637	5.00
6.00	Medicaid charges	11,399,192	6.00
7.00	Medicaid cost (line 1 times line 6)	4,723,301	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (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
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	66,501	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP 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	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	255	14,143	14,398	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	106	14,143	14,249	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	106	14,143	14,249	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, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,787,356	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	292,189	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	449,521	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	2,337,835	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,126,023	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,140,272	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,140,272	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/15/2017 10:44 am

		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		716,129	716,129	-78,810	637,319	1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG		0	0	165,577	165,577	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,340,176	1,340,176	22,921	1,363,097	2.00
3.00	00300	OTHER CAP RELATED COST		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,416,681	4,416,681	0	4,416,681	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,993,277	2,888,297	5,881,574	-54,912	5,826,662	5.00
6.00	00600	MAINTENANCE & REPAIRS	199,970	9,431	209,401	0	209,401	6.00
7.00	00700	OPERATION OF PLANT	0	516,227	516,227	73,691	589,918	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	37,858	37,858	0	37,858	8.00
9.00	00900	HOUSEKEEPING	194,492	186,280	380,772	0	380,772	9.00
10.00	01000	DIETARY	148,454	115,809	264,263	26,725	290,988	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	122,099	530	122,629	0	122,629	13.00
15.00	01500	PHARMACY	0	2,047,082	2,047,082	0	2,047,082	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	289,010	75,389	364,399	0	364,399	16.00
17.00	01700	SOCIAL SERVICE	15,383	14,552	29,935	0	29,935	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	573,917	573,917	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	941,777	597,835	1,539,612	-5,442	1,534,170	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	552,192	822,833	1,375,025	-394,447	980,578	50.00
53.00	05300	ANESTHESIOLOGY	241,917	386,829	628,746	-581,448	47,298	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	445,549	200,021	645,570	-56,429	589,141	54.00
54.01	05401	ULTRASOUND	111,525	40,826	152,351	216	152,567	54.01
56.00	05600	RADIOISOTOPE	0	342,568	342,568	3,971	346,539	56.00
57.00	05700	CT SCAN	0	108,738	108,738	31,587	140,325	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	106,448	106,448	24,842	131,290	58.00
60.00	06000	LABORATORY	516,772	932,392	1,449,164	-12,889	1,436,275	60.00
65.00	06500	RESPIRATORY THERAPY	44,548	25,580	70,128	0	70,128	65.00
66.00	06600	PHYSICAL THERAPY	591,250	90,403	681,653	-29,782	651,871	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	29,119	1,924	31,043	8,702	39,745	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	971	971	130,755	131,726	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	326,813	326,813	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	74,400	74,400	0	74,400	75.01
75.02	03952	WOUND CENTER	0	114,625	114,625	0	114,625	75.02
76.00	03953	CARDIAC REHAB	93,355	2,741	96,096	0	96,096	76.00
76.01	03030	DIABETES EDUCATION	74,015	4,475	78,490	-26,725	51,765	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,524,873	1,680,833	6,205,706	-7,951	6,197,755	88.00
91.00	09100	EMERGENCY	658,381	1,131,616	1,789,997	-41,398	1,748,599	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	583,363	165,626	748,989	-27,348	721,641	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		56,977	56,977	-56,977	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,371,321	19,253,102	32,624,423	15,159	32,639,582	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	417,503	130,098	547,601	-12,937	534,664	194.00
194.01	07951	THE CENTER - FITNESS CENTER	68,829	10,440	79,269	-2,222	77,047	194.01
200.00		TOTAL (SUM OF LINES 118-199)	13,857,653	19,393,640	33,251,293	0	33,251,293	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/15/2017 10:44 am

		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	-55,318	582,001	1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	0	165,577	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-116,578	1,246,519	2.00
3.00	00300	OTHER CAP RELATED COST	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-937,321	3,479,360	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,006,920	4,819,742	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	209,401	6.00
7.00	00700	OPERATION OF PLANT	0	589,918	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	37,858	8.00
9.00	00900	HOUSEKEEPING	0	380,772	9.00
10.00	01000	DIETARY	-44,838	246,150	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	122,629	13.00
15.00	01500	PHARMACY	-990,977	1,056,105	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,394	362,005	16.00
17.00	01700	SOCIAL SERVICE	0	29,935	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-573,917	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-361,302	1,172,868	30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	980,578	50.00
53.00	05300	ANESTHESIOLOGY	0	47,298	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	-3,024	586,117	54.00
54.01	05401	ULTRASOUND	0	152,567	54.01
56.00	05600	RADIOISOTOPE	0	346,539	56.00
57.00	05700	CT SCAN	0	140,325	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	131,290	58.00
60.00	06000	LABORATORY	0	1,436,275	60.00
65.00	06500	RESPIRATORY THERAPY	0	70,128	65.00
66.00	06600	PHYSICAL THERAPY	0	651,871	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	39,745	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-12	131,714	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	326,813	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	74,400	75.01
75.02	03952	WOUND CENTER	0	114,625	75.02
76.00	03953	CARDIAC REHAB	0	96,096	76.00
76.01	03030	DIABETES EDUCATION	0	51,765	76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	-79,145	6,118,610	88.00
91.00	09100	EMERGENCY	-330,166	1,418,433	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0	721,641	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,501,912	28,137,670	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
194.00	07950	FREESTANDING CLINICS	0	534,664	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	77,047	194.01
200.00		TOTAL (SUM OF LINES 118-199)	-4,501,912	28,749,381	200.00

RECLASSIFICATIONS | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/15/2017 10:44 am

	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	130,755	1.00
2.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	326,813	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		0	457,568	
	B - TO RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	55,318	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,659	2.00
	0		0	56,977	
	C - TO RECLASS EKG SALARIES				
1.00	ELECTROCARDIOLOGY	69.00	12,889	0	1.00
	0		12,889	0	
	D - TO RECLASS PROPERTY INSURANCE				
1.00	OTHER CAP RELATED COST	3.00	0	54,370	1.00
	0		0	54,370	
	E - TO RECLASS TELEPHONE EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,608	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	0		0	12,608	
	G - TO RECLASS CRNA EXPENSES				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	241,917	332,000	1.00
	0		241,917	332,000	
	H - TO RECLASS NORTHCAMPUS BLDG				
1.00	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	159,792	1.00
	0		0	159,792	
	I - TO RECLASS CT SCAN				
1.00	CT SCAN	57.00	31,587	0	1.00
	0		31,587	0	
	J - TO RECLASS RECRUITMENT EXPENSE				
1.00	RURAL HEALTH CLINIC	88.00	0	31,667	1.00
	0		0	31,667	
	K - TO RECLASS STRESS TEST SALARIES				
1.00	RADIOISOTOPE	56.00	3,971	0	1.00
2.00	ULTRASOUND	54.01	216	0	2.00
	0		4,187	0	
	L - TO RECLASS MRI SALARIES				
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	24,842	0	1.00
	0		24,842	0	
	M - TO RECLASS DIETARY SALARIES				
1.00	DIETARY	10.00	26,725	0	1.00
	0		26,725	0	
	O - UTILITY EXPENSE				
1.00	OPERATION OF PLANT	7.00	0	73,691	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	0		0	73,691	
	P - HOME HEALTH BILLER				
1.00	ADMINISTRATIVE & GENERAL	5.00	16,858	0	1.00
	TOTALS		16,858	0	
	Q - RHC - HOSPITAL SUPPORT				
1.00	ADULTS & PEDIATRICS	30.00	8,750	0	1.00
	TOTALS		8,750	0	
500.00	Grand Total: Increases		367,755	1,178,673	500.00

RECLASSIFICATIONS | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/15/2017 10:44 am

	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	394,447	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	14,192	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	7,531	0		3.00
4.00	EMERGENCY	91.00	0	41,398	0		4.00
	0		0	457,568			
	B - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	56,977	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	56,977			
	C - TO RECLASS EKG SALARIES						
1.00	LABORATORY	60.00	12,889	0	0		1.00
	0		12,889	0			
	D - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	54,370	12		1.00
	0		0	54,370			
	E - TO RECLASS TELEPHONE EXPENSE						
1.00	PHYSICAL THERAPY	66.00	0	697	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	9,681	0		2.00
3.00	FREESTANDING CLINICS	194.00	0	1,594	0		3.00
4.00	HOME HEALTH AGENCY	101.00	0	549	0		4.00
5.00	THE CENTER - FITNESS CENTER	194.01	0	87	0		5.00
	0		0	12,608			
	G - TO RECLASS CRNA EXPENSES						
1.00	ANESTHESIOLOGY	53.00	241,917	332,000	0		1.00
	0		241,917	332,000			
	H - TO RECLASS NORTHCAMPUS BLDG						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	159,792	9		1.00
	0		0	159,792			
	I - TO RECLASS CT SCAN						
1.00	RADIOLOGY - DIAGNOSTIC	54.00	31,587	0	0		1.00
	0		31,587	0			
	J - TO RECLASS RECRUITMENT EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	31,667	0		1.00
	0		0	31,667			
	K - TO RECLASS STRESS TEST SALARIES						
1.00	ELECTROCARDIOLOGY	69.00	4,187	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		4,187	0			
	L - TO RECLASS MRI SALARIES						
1.00	RADIOLOGY - DIAGNOSTIC	54.00	24,842	0	0		1.00
	0		24,842	0			
	M - TO RECLASS DIETARY SALARIES						
1.00	DIABETES EDUCATION	76.01	26,725	0	0		1.00
	0		26,725	0			
	O - UTILITY EXPENSE						
1.00	PHYSICAL THERAPY	66.00	0	29,085	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	21,187	0		2.00
3.00	HOME HEALTH AGENCY	101.00	0	9,941	0		3.00
4.00	FREESTANDING CLINICS	194.00	0	11,343	0		4.00
5.00	THE CENTER - FITNESS CENTER	194.01	0	2,135	0		5.00
	0		0	73,691			
	P - HOME HEALTH BILLER						
1.00	HOME HEALTH AGENCY	101.00	16,858	0	0		1.00
	TOTALS		16,858	0			
	Q - RHC - HOSPITAL SUPPORT						
1.00	RURAL HEALTH CLINIC	88.00	8,750	0	0		1.00
	TOTALS		8,750	0			
500.00	Grand Total: Decreases		367,755	1,178,673			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 11/15/2017 10:44 am

		Beginning Balances	Acquisitions Purchases	Donation	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	90,000	0	90,000	0	1.00
2.00	Land Improvements	845,711	12,422	0	12,422	2,716	2.00
3.00	Buildings and Fixtures	16,710,704	790,458	0	790,458	458,553	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	13,255,564	423,644	0	423,644	1,526,736	6.00
7.00	HIT designated Assets	891,921	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,940,234	1,316,524	0	1,316,524	1,988,005	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	31,940,234	1,316,524	0	1,316,524	1,988,005	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	326,334	0	1.00
2.00	Land Improvements	855,417	0	2.00
3.00	Buildings and Fixtures	17,042,609	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	12,152,472	0	6.00
7.00	HIT designated Assets	891,921	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,268,753	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	31,268,753	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part II Date/Time Prepared: 11/15/2017 10:44 am

	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	716,129	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	1,340,176	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,056,305	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	716,129	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,340,176	2.00
3.00	Total (sum of lines 1-2)	0	2,056,305	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 11/15/2017 10:44 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	14,605,834	0	14,605,834	0.472033	25,664	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	3,292,191	0	3,292,191	0.106397	5,785	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	13,044,393	0	13,044,393	0.421570	22,921	2.00
3.00	Total (sum of lines 1-2)	30,942,418	0	30,942,418	1.000000	54,370	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	25,664	556,337	0	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	5,785	159,792	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	22,921	1,223,598	0	2.00
3.00	Total (sum of lines 1-2)	0	0	54,370	1,939,727	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	0	25,664	0	0	582,001	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	5,785	0	0	165,577	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	22,921	0	0	1,246,519	2.00
3.00	Total (sum of lines 1-2)	0	54,370	0	0	1,994,097	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/15/2017 10:44 am

	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	-55,318	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	-1,659	ADMINISTRATIVE & GENERAL	5.00	11	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	-15,102	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	-765,624			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	-44,838	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	-12	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	-2,394	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	-573,917	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/15/2017 10:44 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-113,245	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	BILL COPY CHARGES	B	-12,293	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-53,517	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	TRANSMED SERVICE REVENUE	B	-4,450	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PHYSICIAN RECRUITMENT COSTS	A	-1,181	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PERSONAL USE OF AUTO	A	-5,805	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	CRNA BENEFITS	A	-34,674	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.05
33.06	MARKETING SALARY	A	-37,731	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MARKETING EXPENSES	A	-112,296	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MARKETING EMPLOYEE BENEFITS	A	-12,026	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09			0		0.00	0	33.09
33.10	LOBBYING EXPENSES	A	-8,710	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	SELF INSURANCE EXPENSE	A	-797,834	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12			0		0.00	0	33.12
33.13	INSURANCE DIVIDEND	B	-515,097	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	RHC SELF INSURANCE EXPENSE	A	-92,787	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	USAC SUBSIDY	B	-48,213	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	EMPLOYEE ACTIVITIES	B	-134	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	340B CONTRACT DEPRECIATION	A	-3,333	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.17
33.18	340B CONTRACT EXPENSES	A	-990,977	PHARMACY	15.00	0	33.18
33.19	HOSPICE REVENUE	A	-7,000	ADULTS & PEDIATRICS	30.00	0	33.19
33.20	PENALTY/INTEREST LATE TAX DEPOSIT	B	-5,543	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	LOSS ON IMPAIRMENT	B	-185,189	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	PHYSICIAN ASSISTANT	B	-1,013	RURAL HEALTH CLINIC	88.00	0	33.22
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,501,912				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 11/15/2017 10:44 am

	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	378,302	354,302	24,000	0	0	1.00
2.00	91.00	EMERGENCY	987,600	330,166	657,434	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	22,000	0	22,000	0	0	3.00
4.00	54.00	RADIOLOGY - DIAGNOSTIC	3,024	3,024	0	0	0	4.00
5.00	60.00	LABORATORY	19,800	0	19,800	0	0	5.00
6.00	88.00	RURAL HEALTH CLINIC	78,132	78,132	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	8,750	0	8,750	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			1,497,608	765,624	731,984		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	30.00	ADULTS & PEDIATRICS	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	354,302	1.00
2.00	91.00	EMERGENCY	0	0	0	330,166	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	3.00
4.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	3,024	4.00
5.00	60.00	LABORATORY	0	0	0	0	5.00
6.00	88.00	RURAL HEALTH CLINIC	0	0	0	78,132	6.00
7.00	30.00	ADULTS & PEDIATRICS	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	765,624	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1349	Period: From 07/01/2016 To 06/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/15/2017 10:44 am
		Occupational Therapy	Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					5	1.00
2.00	Line 1 multiplied by 15 hours per week					75	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	10.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.61	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)	38.31	38.31	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)	785	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)	785	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)	785	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)	76.59	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	5,744	22.00
23.00	Total salary equivalency (see instructions)	5,744	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: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/15/2017 10:44 am

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)	76.61	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)	5,744	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)	5,744	63.00
64.00	Total cost of outside supplier services (from your records)	615	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: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/15/2017 10:44 am

Speech Pathology | Cost

Line	Description	1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	13	1.00
2.00	Line 1 multiplied by 15 hours per week	195	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

Line	Description	Supervisors 1.00	Therapists 2.00	Assistants 3.00	Aides 4.00	Trainees 5.00	
9.00	Total hours worked	0.00	93.75	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.61	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)	36.81	36.81	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

Line	Description	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)	6,901	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)	6,901	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)	6,901	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)	73.61	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	14,354	22.00
23.00	Total salary equivalency (see instructions)	14,354	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: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/15/2017 10:44 am

Speech Pathology | Cost

		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)	73.61	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)	14,354	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)	14,354	63.00
64.00	Total cost of outside supplier services (from your records)	5,625	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: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/15/2017 10:44 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP		
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	582,001	582,001				1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	165,577	0	165,577			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,246,519			1,246,519		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,479,360	0	0	0	3,479,360	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,819,742	55,708	33,530	292,534	761,678	5.00
6.00	00600	MAINTENANCE & REPAIRS	209,401	27,590	0	829	51,242	6.00
7.00	00700	OPERATION OF PLANT	589,918	47,233	4,578	54,666	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	37,858	4,340	0	0	0	8.00
9.00	00900	HOUSEKEEPING	380,772	5,897	0	1,265	49,839	9.00
10.00	01000	DIETARY	246,150	13,573	0	6,650	44,890	10.00
11.00	01100	CAFETERIA	0	7,544	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	122,629	2,528	0	84	31,288	13.00
15.00	01500	PHARMACY	1,056,105	3,805	0	584	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	362,005	12,354	8,338	4,134	74,059	16.00
17.00	01700	SOCIAL SERVICE	29,935	0	0	223	3,942	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,172,868	54,794	0	37,395	243,573	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	980,578	51,153	0	93,612	141,499	50.00
53.00	05300	ANESTHESIOLOGY	47,298	725	0	291	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	586,117	10,221	0	122,032	99,712	54.00
54.01	05401	ULTRASOUND	152,567	2,957	0	65,437	28,634	54.01
56.00	05600	RADIOISOTOPE	346,539	2,372	0	0	1,018	56.00
57.00	05700	CT SCAN	140,325	2,981	0	112,608	8,094	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	131,290	7,643	0	214,460	6,366	58.00
60.00	06000	LABORATORY	1,436,275	14,816	0	23,685	129,120	60.00
65.00	06500	RESPIRATORY THERAPY	70,128	1,507	0	5,335	11,415	65.00
66.00	06600	PHYSICAL THERAPY	651,871	3,961	35,310	31,959	151,508	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	39,745	1,433	0	1,213	9,692	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	131,714	4,703	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	326,813	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	74,400	4,678	0	1,221	0	75.01
75.02	03952	WOUND CENTER	114,625	12,230	0	0	0	75.02
76.00	03953	CARDIAC REHAB	96,096	7,404	0	5,008	23,922	76.00
76.01	03030	DIABETES EDUCATION	51,765	1,557	0	0	12,118	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,118,610	115,964	49,970	76,577	1,157,252	88.00
91.00	09100	EMERGENCY	1,418,433	24,560	0	61,443	168,710	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	721,641	13,515	0	6,646	145,167	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,137,670	519,746	131,726	1,219,891	3,354,738	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,647	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	534,664	60,608	0	12,996	106,985	194.00
194.01	07951	THE CENTER - FITNESS CENTER	77,047	0	33,851	13,632	17,637	194.01
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)	28,749,381	582,001	165,577	1,246,519	3,479,360	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/15/2017 10:44 am

		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	5,963,192	5,963,192				5.00
6.00	00600	MAINTENANCE & REPAIRS	289,062	75,648	364,710			6.00
7.00	00700	OPERATION OF PLANT	696,395	182,248	27,450	906,093		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	42,198	11,043	2,522	7,728	63,491	8.00
9.00	00900	HOUSEKEEPING	437,773	114,566	3,427	10,500	0	9.00
10.00	01000	DIETARY	311,263	81,458	7,888	24,168	6	10.00
11.00	01100	CAFETERIA	7,544	1,974	4,384	13,433	0	11.00
13.00	01300	NURSING ADMINISTRATION	156,529	40,964	1,469	4,502	0	13.00
15.00	01500	PHARMACY	1,060,494	277,533	2,211	6,775	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	460,890	120,616	13,770	42,191	0	16.00
17.00	01700	SOCIAL SERVICE	34,100	8,924	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	1,508,630	394,811	31,844	97,565	16,374	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,266,842	331,535	29,728	91,083	12,601	50.00
53.00	05300	ANESTHESIOLOGY	48,314	12,644	421	1,291	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	818,082	214,094	5,940	18,199	2,146	54.00
54.01	05401	ULTRASOUND	249,595	65,320	1,718	5,265	1,359	54.01
56.00	05600	RADIOISOTOPE	349,929	91,577	1,378	4,223	99	56.00
57.00	05700	CT SCAN	264,008	69,091	1,733	5,309	3,440	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	359,759	94,150	4,442	13,609	2,507	58.00
60.00	06000	LABORATORY	1,603,896	419,743	8,611	26,382	0	60.00
65.00	06500	RESPIRATORY THERAPY	88,385	23,131	876	2,684	0	65.00
66.00	06600	PHYSICAL THERAPY	874,609	228,887	30,212	92,564	2,292	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	52,083	13,630	833	2,552	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	136,417	35,701	2,733	8,374	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	326,813	85,528	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	80,299	21,014	2,719	8,330	0	75.01
75.02	03952	WOUND CENTER	126,855	33,198	7,108	21,777	0	75.02
76.00	03953	CARDIAC REHAB	132,430	34,657	4,303	13,184	0	76.00
76.01	03030	DIABETES EDUCATION	65,440	17,126	905	2,772	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,518,373	1,967,574	81,022	121,011	1,020	88.00
91.00	09100	EMERGENCY	1,673,146	437,866	14,273	43,730	18,149	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	886,969	232,122	7,854	24,065	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,890,314	5,738,373	301,774	713,266	59,993	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,647	431	957	2,933	0	190.00
194.00	07950	FREESTANDING CLINICS	715,253	187,183	35,223	107,918	23	194.00
194.01	07951	THE CENTER - FITNESS CENTER	142,167	37,205	26,756	81,976	3,475	194.01
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)	28,749,381	5,963,192	364,710	906,093	63,491	202.00

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		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	566,266					9.00
10.00	01000	DIETARY	2,889	427,672				10.00
11.00	01100	CAFETERIA	14,652	337,407	379,394			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	24,756	228,220		13.00
15.00	01500	PHARMACY	3,122	0	20,580	0	1,370,715	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,820	0	80,830	0	0	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	92,855	90,265	84,110	103,285	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	82,791	0	38,327	51,964	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	13,214	0	15,212	0	0	54.00
54.01	05401	ULTRASOUND	6,504	0	1,939	0	0	54.01
56.00	05600	RADIOISOTOPE	2,259	0	597	0	0	56.00
57.00	05700	CT SCAN	5,896	0	5,369	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,790	0	0	58.00
60.00	06000	LABORATORY	11,064	0	42,055	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	589	0	11,036	4,455	0	65.00
66.00	06600	PHYSICAL THERAPY	17,503	0	149	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	1,370,715	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	3,410	0	0	0	0	75.01
75.02	03952	WOUND CENTER	219	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	4,930	0	3,877	0	0	76.00
76.01	03030	DIABETES EDUCATION	548	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	181,432	0	11,036	0	0	88.00
91.00	09100	EMERGENCY	56,951	0	33,257	68,516	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,807	0	1,939	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	507,455	427,672	376,859	228,220	1,370,715	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	36,233	0	2,535	0	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	22,578	0	0	0	0	194.01
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)	566,266	427,672	379,394	228,220	1,370,715	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/15/2017 10:44 am

		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	722,117					16.00
17.00	01700	SOCIAL SERVICE	0	43,024				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	47,475	43,024	0	2,510,238	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	56,533	0	0	1,961,404	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	62,670	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	19,989	0	0	1,106,876	0	54.00
54.01	05401	ULTRASOUND	4,997	0	0	336,697	0	54.01
56.00	05600	RADIOISOTOPE	4,373	0	0	454,435	0	56.00
57.00	05700	CT SCAN	4,060	0	0	358,906	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,123	0	0	479,380	0	58.00
60.00	06000	LABORATORY	42,790	0	0	2,154,541	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	131,156	0	65.00
66.00	06600	PHYSICAL THERAPY	312	0	0	1,246,528	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	69,098	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	183,225	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	412,341	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,370,715	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	2,811	0	0	118,583	0	75.01
75.02	03952	WOUND CENTER	2,186	0	0	191,343	0	75.02
76.00	03953	CARDIAC REHAB	1,874	0	0	195,255	0	76.00
76.01	03030	DIABETES EDUCATION	0	0	0	86,791	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	454,135	0	0	10,335,603	0	88.00
91.00	09100	EMERGENCY	52,160	0	0	2,398,048	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	1,155,756	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	696,818	43,024	0	27,319,589	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	5,968	0	190.00
194.00	07950	FREESTANDING CLINICS	25,299	0	0	1,109,667	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	0	0	314,157	0	194.01
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)	722,117	43,024	0	28,749,381	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/15/2017 10:44 am

		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	2,510,238	30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	1,961,404	50.00
53.00	05300	ANESTHESIOLOGY	62,670	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,106,876	54.00
54.01	05401	ULTRASOUND	336,697	54.01
56.00	05600	RADIOISOTOPE	454,435	56.00
57.00	05700	CT SCAN	358,906	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	479,380	58.00
60.00	06000	LABORATORY	2,154,541	60.00
65.00	06500	RESPIRATORY THERAPY	131,156	65.00
66.00	06600	PHYSICAL THERAPY	1,246,528	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	69,098	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	183,225	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	412,341	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,370,715	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	75.00
75.01	03951	SLEEP LAB	118,583	75.01
75.02	03952	WOUND CENTER	191,343	75.02
76.00	03953	CARDIAC REHAB	195,255	76.00
76.01	03030	DIABETES EDUCATION	86,791	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	10,335,603	88.00
91.00	09100	EMERGENCY	2,398,048	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY	1,155,756	101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,319,589	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	5,968	190.00
194.00	07950	FREESTANDING CLINICS	1,109,667	194.00
194.01	07951	THE CENTER - FITNESS CENTER	314,157	194.01
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	28,749,381	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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		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	110,740	55,708	33,530	292,534	492,512	5.00
6.00	00600	MAINTENANCE & REPAIRS	261	27,590	0	829	28,680	6.00
7.00	00700	OPERATION OF PLANT	34	47,233	4,578	54,666	106,511	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,340	0	0	4,340	8.00
9.00	00900	HOUSEKEEPING	0	5,897	0	1,265	7,162	9.00
10.00	01000	DIETARY	0	13,573	0	6,650	20,223	10.00
11.00	01100	CAFETERIA	0	7,544	0	0	7,544	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,528	0	84	2,612	13.00
15.00	01500	PHARMACY	7,104	3,805	0	584	11,493	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,354	8,338	4,134	24,826	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	223	223	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,313	54,794	0	37,395	120,502	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,394	51,153	0	93,612	195,159	50.00
53.00	05300	ANESTHESIOLOGY	0	725	0	291	1,016	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	10,221	0	122,032	132,253	54.00
54.01	05401	ULTRASOUND	0	2,957	0	65,437	68,394	54.01
56.00	05600	RADIOISOTOPE	0	2,372	0	0	2,372	56.00
57.00	05700	CT SCAN	0	2,981	0	112,608	115,589	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	7,643	0	214,460	222,103	58.00
60.00	06000	LABORATORY	130	14,816	0	23,685	38,631	60.00
65.00	06500	RESPIRATORY THERAPY	11,033	1,507	0	5,335	17,875	65.00
66.00	06600	PHYSICAL THERAPY	0	3,961	35,310	31,959	71,230	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	1,433	0	1,213	2,646	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,703	0	0	4,703	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	4,678	0	1,221	5,899	75.01
75.02	03952	WOUND CENTER	0	12,230	0	0	12,230	75.02
76.00	03953	CARDIAC REHAB	0	7,404	0	5,008	12,412	76.00
76.01	03030	DIABETES EDUCATION	0	1,557	0	0	1,557	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,756	115,964	49,970	76,577	257,267	88.00
91.00	09100	EMERGENCY	10,439	24,560	0	61,443	96,442	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	13,515	0	6,646	20,161	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	233,204	519,746	131,726	1,219,891	2,104,567	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,647	0	0	1,647	190.00
194.00	07950	FREESTANDING CLINICS	0	60,608	0	12,996	73,604	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	0	33,851	13,632	47,483	194.01
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)	233,204	582,001	165,577	1,246,519	2,227,301	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/15/2017 10:44 am

		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	492,512				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	6,248	34,928			6.00
7.00	00700	OPERATION OF PLANT	0	15,052	2,629	124,192		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	912	242	1,059	6,553	8.00
9.00	00900	HOUSEKEEPING	0	9,462	328	1,439	0	9.00
10.00	01000	DIETARY	0	6,728	755	3,312	1	10.00
11.00	01100	CAFETERIA	0	163	420	1,841	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,383	141	617	0	13.00
15.00	01500	PHARMACY	0	22,922	212	929	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,962	1,319	5,783	0	16.00
17.00	01700	SOCIAL SERVICE	0	737	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	32,608	3,050	13,373	1,690	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	27,382	2,847	12,484	1,301	50.00
53.00	05300	ANESTHESIOLOGY	0	1,044	40	177	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	17,682	569	2,494	221	54.00
54.01	05401	ULTRASOUND	0	5,395	165	722	140	54.01
56.00	05600	RADIOISOTOPE	0	7,563	132	579	10	56.00
57.00	05700	CT SCAN	0	5,706	166	728	355	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	7,776	425	1,865	259	58.00
60.00	06000	LABORATORY	0	34,667	825	3,616	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,910	84	368	0	65.00
66.00	06600	PHYSICAL THERAPY	0	18,904	2,893	12,687	237	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	1,126	80	350	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,949	262	1,148	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	7,064	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	1,736	260	1,142	0	75.01
75.02	03952	WOUND CENTER	0	2,742	681	2,985	0	75.02
76.00	03953	CARDIAC REHAB	0	2,862	412	1,807	0	76.00
76.01	03030	DIABETES EDUCATION	0	1,414	87	380	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	162,511	7,758	16,585	105	88.00
91.00	09100	EMERGENCY	0	36,163	1,367	5,994	1,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	19,171	752	3,298	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	473,944	28,901	97,762	6,192	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	36	92	402	0	190.00
194.00	07950	FREESTANDING CLINICS	0	15,459	3,373	14,792	2	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	3,073	2,562	11,236	359	194.01
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	492,512	34,928	124,192	6,553	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/15/2017 10:44 am

		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	18,391					9.00
10.00	01000	DIETARY	94	31,113				10.00
11.00	01100	CAFETERIA	476	24,546	34,990			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,283	9,036		13.00
15.00	01500	PHARMACY	101	0	1,898	0	37,555	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	124	0	7,455	0	0	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	3,016	6,567	7,755	4,090	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,689	0	3,535	2,057	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	429	0	1,403	0	0	54.00
54.01	05401	ULTRASOUND	211	0	179	0	0	54.01
56.00	05600	RADIOISOTOPE	73	0	55	0	0	56.00
57.00	05700	CT SCAN	192	0	495	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	165	0	0	58.00
60.00	06000	LABORATORY	359	0	3,879	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	19	0	1,018	176	0	65.00
66.00	06600	PHYSICAL THERAPY	568	0	14	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	37,555	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	111	0	0	0	0	75.01
75.02	03952	WOUND CENTER	7	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	160	0	358	0	0	76.00
76.01	03030	DIABETES EDUCATION	18	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,893	0	1,018	0	0	88.00
91.00	09100	EMERGENCY	1,850	0	3,067	2,713	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	91	0	179	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,481	31,113	34,756	9,036	37,555	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	1,177	0	234	0	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	733	0	0	0	0	194.01
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)	18,391	31,113	34,990	9,036	37,555	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/15/2017 10:44 am

		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	49,469					16.00
17.00	01700	SOCIAL SERVICE	0	960				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,252	960		196,863	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,873	0		251,327	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		2,277	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,369	0		156,420	0	54.00
54.01	05401	ULTRASOUND	342	0		75,548	0	54.01
56.00	05600	RADIOISOTOPE	300	0		11,084	0	56.00
57.00	05700	CT SCAN	278	0		123,509	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	214	0		232,807	0	58.00
60.00	06000	LABORATORY	2,931	0		84,908	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0		21,450	0	65.00
66.00	06600	PHYSICAL THERAPY	21	0		106,554	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		4,202	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		9,062	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		7,064	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		37,555	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	75.00
75.01	03951	SLEEP LAB	193	0		9,341	0	75.01
75.02	03952	WOUND CENTER	150	0		18,795	0	75.02
76.00	03953	CARDIAC REHAB	128	0		18,139	0	76.00
76.01	03030	DIABETES EDUCATION	0	0		3,456	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	31,112	0		482,249	0	88.00
91.00	09100	EMERGENCY	3,573	0		153,042	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		43,652	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,736	960	0	2,049,304	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		2,177	0	190.00
194.00	07950	FREESTANDING CLINICS	1,733	0		110,374	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	0		65,446	0	194.01
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)	49,469	960	0	2,227,301	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/15/2017 10:44 am

		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	196,863	30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	251,327	50.00
53.00	05300	ANESTHESIOLOGY	2,277	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	156,420	54.00
54.01	05401	ULTRASOUND	75,548	54.01
56.00	05600	RADIOISOTOPE	11,084	56.00
57.00	05700	CT SCAN	123,509	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	232,807	58.00
60.00	06000	LABORATORY	84,908	60.00
65.00	06500	RESPIRATORY THERAPY	21,450	65.00
66.00	06600	PHYSICAL THERAPY	106,554	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,202	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,062	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	7,064	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,555	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	75.00
75.01	03951	SLEEP LAB	9,341	75.01
75.02	03952	WOUND CENTER	18,795	75.02
76.00	03953	CARDIAC REHAB	18,139	76.00
76.01	03030	DIABETES EDUCATION	3,456	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	482,249	88.00
91.00	09100	EMERGENCY	153,042	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY	43,652	101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,049,304	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,177	190.00
194.00	07950	FREESTANDING CLINICS	110,374	194.00
194.01	07951	THE CENTER - FITNESS CENTER	65,446	194.01
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	2,227,301	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/15/2017 10:44 am

		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			1,223,597			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	13,578,003		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,764	5,537	287,154	2,972,402	-5,963,192	5.00
6.00	00600	MAINTENANCE & REPAIRS	3,350	0	814	199,970	0	6.00
7.00	00700	OPERATION OF PLANT	5,735	756	53,661	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	527	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	716	0	1,242	194,492	0	9.00
10.00	01000	DIETARY	1,648	0	6,528	175,179	0	10.00
11.00	01100	CAFETERIA	916	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	307	0	82	122,099	0	13.00
15.00	01500	PHARMACY	462	0	573	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,500	1,377	4,058	289,010	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	219	15,383	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	36,707	950,527	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,211	0	91,891	552,192	0	50.00
53.00	05300	ANESTHESIOLOGY	88	0	286	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,241	0	119,788	389,120	0	54.00
54.01	05401	ULTRASOUND	359	0	64,234	111,741	0	54.01
56.00	05600	RADIOISOTOPE	288	0	0	3,971	0	56.00
57.00	05700	CT SCAN	362	0	110,537	31,587	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	928	0	210,516	24,842	0	58.00
60.00	06000	LABORATORY	1,799	0	23,249	503,883	0	60.00
65.00	06500	RESPIRATORY THERAPY	183	0	5,237	44,548	0	65.00
66.00	06600	PHYSICAL THERAPY	481	5,831	31,371	591,250	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	1,191	37,821	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	571	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	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	4,916	93,355	0	76.00
76.01	03030	DIABETES EDUCATION	189	0	0	47,290	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,080	8,252	75,169	4,516,123	0	88.00
91.00	09100	EMERGENCY	2,982	0	60,313	658,381	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	6,524	566,505	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	63,107	21,753	1,197,459	13,091,671	-5,963,192	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	12,757	417,503	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	5,590	13,381	68,829	0	194.01
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)	582,001	165,577	1,246,519	3,479,360		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.235941	6.055554	1.018733	0.256250		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: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/15/2017 10:44 am

		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	22,786,189					5.00
6.00	00600	MAINTENANCE & REPAIRS	289,062	76,197				6.00
7.00	00700	OPERATION OF PLANT	696,395	5,735	61,787			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	42,198	527	527	10,888		8.00
9.00	00900	HOUSEKEEPING	437,773	716	716	0	206,765	9.00
10.00	01000	DIETARY	311,263	1,648	1,648	1	1,055	10.00
11.00	01100	CAFETERIA	7,544	916	916	0	5,350	11.00
13.00	01300	NURSING ADMINISTRATION	156,529	307	307	0	0	13.00
15.00	01500	PHARMACY	1,060,494	462	462	0	1,140	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	460,890	2,877	2,877	0	1,395	16.00
17.00	01700	SOCIAL SERVICE	34,100	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	1,508,630	6,653	6,653	2,808	33,905	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,266,842	6,211	6,211	2,161	30,230	50.00
53.00	05300	ANESTHESIOLOGY	48,314	88	88	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	818,082	1,241	1,241	368	4,825	54.00
54.01	05401	ULTRASOUND	249,595	359	359	233	2,375	54.01
56.00	05600	RADIOISOTOPE	349,929	288	288	17	825	56.00
57.00	05700	CT SCAN	264,008	362	362	590	2,153	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	359,759	928	928	430	0	58.00
60.00	06000	LABORATORY	1,603,896	1,799	1,799	0	4,040	60.00
65.00	06500	RESPIRATORY THERAPY	88,385	183	183	0	215	65.00
66.00	06600	PHYSICAL THERAPY	874,609	6,312	6,312	393	6,391	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	52,083	174	174	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	136,417	571	571	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	326,813	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	80,299	568	568	0	1,245	75.01
75.02	03952	WOUND CENTER	126,855	1,485	1,485	0	80	75.02
76.00	03953	CARDIAC REHAB	132,430	899	899	0	1,800	76.00
76.01	03030	DIABETES EDUCATION	65,440	189	189	0	200	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,518,373	16,927	8,252	175	66,247	88.00
91.00	09100	EMERGENCY	1,673,146	2,982	2,982	3,112	20,795	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	886,969	1,641	1,641	0	1,025	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,927,122	63,048	48,638	10,288	185,291	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,647	200	200	0	0	190.00
194.00	07950	FREESTANDING CLINICS	715,253	7,359	7,359	4	13,230	194.00
194.01	07951	THE CENTER - FITNESS CENTER	142,167	5,590	5,590	596	8,244	194.01
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)	5,963,192	364,710	906,093	63,491	566,266	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.261702	4.786409	14.664784	5.831282	2.738694	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	492,512	34,928	124,192	6,553	18,391	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.021614	0.458391	2.010002	0.601855	0.088946	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/15/2017 10:44 am

		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	28,423					10.00
11.00	01100	CAFETERIA	22,424	2,544				11.00
13.00	01300	NURSING ADMINISTRATION	0	166	91,483			13.00
15.00	01500	PHARMACY	0	138	0	2,047,082		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	542	0	0	2,312	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	5,999	564	41,402	0	152	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	257	20,830	0	181	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	102	0	0	64	54.00
54.01	05401	ULTRASOUND	0	13	0	0	16	54.01
56.00	05600	RADIOISOTOPE	0	4	0	0	14	56.00
57.00	05700	CT SCAN	0	36	0	0	13	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	12	0	0	10	58.00
60.00	06000	LABORATORY	0	282	0	0	137	60.00
65.00	06500	RESPIRATORY THERAPY	0	74	1,786	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1	0	0	1	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	2,047,082	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	9	75.01
75.02	03952	WOUND CENTER	0	0	0	0	7	75.02
76.00	03953	CARDIAC REHAB	0	26	0	0	6	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	74	0	0	1,454	88.00
91.00	09100	EMERGENCY	0	223	27,465	0	167	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	13	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,423	2,527	91,483	2,047,082	2,231	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	17	0	0	81	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	0	0	0	0	194.01
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)	427,672	379,394	228,220	1,370,715	722,117	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.046688	149.132862	2.494671	0.669595	312.334343	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	31,113	34,990	9,036	37,555	49,469	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.094642	13.753931	0.098772	0.018346	21.396626	205.00

		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	953		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	953	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)	953	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
194.01	07951	THE CENTER - FITNESS CENTER	0	0	194.01
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)	43,024	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	45.145855	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	960	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.007345	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I | Date/Time Prepared: 11/15/2017 10:44 am

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	2,510,238		2,510,238	0	0	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,961,404		1,961,404	0	0	50.00
53.00	05300	ANESTHESIOLOGY	62,670		62,670	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,106,876		1,106,876	0	0	54.00
54.01	05401	ULTRASOUND	336,697		336,697	0	0	54.01
56.00	05600	RADIOISOTOPE	454,435		454,435	0	0	56.00
57.00	05700	CT SCAN	358,906		358,906	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	479,380		479,380	0	0	58.00
60.00	06000	LABORATORY	2,154,541		2,154,541	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	131,156	0	131,156	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,246,528	0	1,246,528	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	69,098		69,098	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	183,225		183,225	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	412,341		412,341	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,370,715		1,370,715	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	75.00
75.01	03951	SLEEP LAB	118,583		118,583	0	0	75.01
75.02	03952	WOUND CENTER	191,343		191,343	0	0	75.02
76.00	03953	CARDIAC REHAB	195,255		195,255	0	0	76.00
76.01	03030	DIABETES EDUCATION	86,791		86,791	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	10,335,603		10,335,603	0	0	88.00
91.00	09100	EMERGENCY	2,398,048		2,398,048	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	469,793		469,793		0	92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,155,756		1,155,756		0	101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	27,789,382	0	27,789,382	0	0	200.00
201.00		Less Observation Beds	469,793		469,793		0	201.00
202.00		Total (see instructions)	27,319,589	0	27,319,589	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I | Date/Time Prepared: 11/15/2017 10:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,025,250		1,025,250			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	383,184	4,539,403	4,922,587	0.398450	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	29,268	108,222	137,490	0.455815	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	56,421	2,983,832	3,040,253	0.364074	0.000000	54.00
54.01	05401	ULTRASOUND	201,376	3,493,362	3,694,738	0.091129	0.000000	54.01
56.00	05600	RADIOISOTOPE	33,252	1,606,632	1,639,884	0.277114	0.000000	56.00
57.00	05700	CT SCAN	162,441	10,241,733	10,404,174	0.034496	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	46,957	2,840,675	2,887,632	0.166011	0.000000	58.00
60.00	06000	LABORATORY	550,282	10,411,332	10,961,614	0.196553	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	31,481	335,284	366,765	0.357602	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	404,357	4,648,949	5,053,306	0.246676	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	18,354	414,892	433,246	0.159489	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	146,791	890,315	1,037,106	0.176670	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	301,204	272,377	573,581	0.718889	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	358,281	2,229,695	2,587,976	0.529647	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	2,962	481,810	484,772	0.244616	0.000000	75.01
75.02	03952	WOUND CENTER	0	430,929	430,929	0.444024	0.000000	75.02
76.00	03953	CARDIAC REHAB	0	285,503	285,503	0.683898	0.000000	76.00
76.01	03030	DIABETES EDUCATION	0	32,852	32,852	2.641879	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,327,779	7,327,779			88.00
91.00	09100	EMERGENCY	45,871	6,459,947	6,505,818	0.368601	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,336	219,186	222,522	2.111220	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,877,184	1,877,184			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	3,801,068	62,131,893	65,932,961			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,801,068	62,131,893	65,932,961			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I | Date/Time Prepared: 11/15/2017 10:44 am

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: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/15/2017 10:44 am

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	251,327	4,922,587	0.051056	187,044	9,550	50.00
53.00	05300	ANESTHESIOLOGY	2,277	137,490	0.016561	13,042	216	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	156,420	3,040,253	0.051450	36,819	1,894	54.00
54.01	05401	ULTRASOUND	75,548	3,694,738	0.020447	136,776	2,797	54.01
56.00	05600	RADIOISOTOPE	11,084	1,639,884	0.006759	18,288	124	56.00
57.00	05700	CT SCAN	123,509	10,404,174	0.011871	102,783	1,220	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	232,807	2,887,632	0.080622	24,024	1,937	58.00
60.00	06000	LABORATORY	84,908	10,961,614	0.007746	334,224	2,589	60.00
65.00	06500	RESPIRATORY THERAPY	21,450	366,765	0.058484	16,487	964	65.00
66.00	06600	PHYSICAL THERAPY	106,554	5,053,306	0.021086	117,788	2,484	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	4,202	433,246	0.009699	11,454	111	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,062	1,037,106	0.008738	69,645	609	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	7,064	573,581	0.012316	183,118	2,255	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,555	2,587,976	0.014511	116,716	1,694	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	75.00
75.01	03951	SLEEP LAB	9,341	484,772	0.019269	2,002	39	75.01
75.02	03952	WOUND CENTER	18,795	430,929	0.043615	0	0	75.02
76.00	03953	CARDIAC REHAB	18,139	285,503	0.063533	0	0	76.00
76.01	03030	DIABETES EDUCATION	3,456	32,852	0.105199	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	482,249	7,327,779	0.065811	0	0	88.00
91.00	09100	EMERGENCY	153,042	6,505,818	0.023524	111	3	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	36,843	222,522	0.165570	0	0	92.00
200.00		Total (lines 50-199)	1,845,632	63,030,527		1,370,321	28,486	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1349

Period: From 07/01/2016 To 06/30/2017

Worksheet D Part IV

Date/Time Prepared: 11/15/2017 10:44 am

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: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/15/2017 10:44 am

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	4,922,587	0.000000	0.000000	187,044	50.00
53.00	05300	ANESTHESIOLOGY	0	137,490	0.000000	0.000000	13,042	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	3,040,253	0.000000	0.000000	36,819	54.00
54.01	05401	ULTRASOUND	0	3,694,738	0.000000	0.000000	136,776	54.01
56.00	05600	RADIOISOTOPE	0	1,639,884	0.000000	0.000000	18,288	56.00
57.00	05700	CT SCAN	0	10,404,174	0.000000	0.000000	102,783	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,887,632	0.000000	0.000000	24,024	58.00
60.00	06000	LABORATORY	0	10,961,614	0.000000	0.000000	334,224	60.00
65.00	06500	RESPIRATORY THERAPY	0	366,765	0.000000	0.000000	16,487	65.00
66.00	06600	PHYSICAL THERAPY	0	5,053,306	0.000000	0.000000	117,788	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	433,246	0.000000	0.000000	11,454	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,037,106	0.000000	0.000000	69,645	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	573,581	0.000000	0.000000	183,118	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,587,976	0.000000	0.000000	116,716	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	484,772	0.000000	0.000000	2,002	75.01
75.02	03952	WOUND CENTER	0	430,929	0.000000	0.000000	0	75.02
76.00	03953	CARDIAC REHAB	0	285,503	0.000000	0.000000	0	76.00
76.01	03030	DIABETES EDUCATION	0	32,852	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,327,779	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	6,505,818	0.000000	0.000000	111	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	222,522	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	63,030,527			1,370,321	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/15/2017 10:44 am

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: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/15/2017 10:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.398450	0	1,807,888	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.455815	0	26,544	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.364074	0	794,630	0	0	54.00
54.01	05401	ULTRASOUND	0.091129	0	1,396,669	0	0	54.01
56.00	05600	RADIOISOTOPE	0.277114	0	827,645	0	0	56.00
57.00	05700	CT SCAN	0.034496	0	4,051,604	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.166011	0	955,432	0	0	58.00
60.00	06000	LABORATORY	0.196553	0	4,003,628	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.357602	0	165,474	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.246676	0	1,553,181	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	0.159489	0	181,918	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.176670	0	267,434	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.718889	0	85,111	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.529647	0	1,613,969	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	0.244616	0	147,058	0	0	75.01
75.02	03952	WOUND CENTER	0.444024	0	255,833	0	0	75.02
76.00	03953	CARDIAC REHAB	0.683898	0	173,041	0	0	76.00
76.01	03030	DIABETES EDUCATION	2.641879	0	9,358	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.368601	0	1,585,822	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.111220	0	117,277	0	0	92.00
200.00		Subtotal (see instructions)		0	20,019,516	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	20,019,516	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/15/2017 10:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	720,353	0	50.00
53.00	05300	ANESTHESIOLOGY	12,099	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	289,304	0	54.00
54.01	05401	ULTRASOUND	127,277	0	54.01
56.00	05600	RADIOISOTOPE	229,352	0	56.00
57.00	05700	CT SCAN	139,764	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	158,612	0	58.00
60.00	06000	LABORATORY	786,925	0	60.00
65.00	06500	RESPIRATORY THERAPY	59,174	0	65.00
66.00	06600	PHYSICAL THERAPY	383,132	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	29,014	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,248	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	61,185	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	854,834	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	75.00
75.01	03951	SLEEP LAB	35,973	0	75.01
75.02	03952	WOUND CENTER	113,596	0	75.02
76.00	03953	CARDIAC REHAB	118,342	0	76.00
76.01	03030	DIABETES EDUCATION	24,723	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	584,536	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	247,598	0	92.00
200.00		Subtotal (see instructions)	5,023,041	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	5,023,041	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1349 | Component CCN: 14-Z349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V | Date/Time Prepared: 11/15/2017 10:44 am

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	0.398450	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.455815	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.364074	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.091129	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.277114	0	0	0	0	56.00
57.00	05700	CT SCAN	0.034496	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.166011	0	0	0	0	58.00
60.00	06000	LABORATORY	0.196553	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.357602	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.246676	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	0.159489	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.176670	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.718889	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.529647	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	0.244616	0	0	0	0	75.01
75.02	03952	WOUND CENTER	0.444024	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	0.683898	0	0	0	0	76.00
76.01	03030	DIABETES EDUCATION	2.641879	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	0.368601	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.111220	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: 14-1349 | Component CCN: 14-Z349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V | Date/Time Prepared: 11/15/2017 10:44 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
	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: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/15/2017 10:44 am

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)	1,928	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,313	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)	953	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	305	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)	305	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	3	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)	2	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	653	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)	240	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)	239	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	150.15	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)	2,510,238	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)	450	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)	300	25.00
26.00	Total swing-bed cost (see instructions)	796,794	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,713,444	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)	1,713,444	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)	1,304.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	852,158	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)	852,158	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/15/2017 10:44 am

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)	427,710	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,279,868	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)	313,198	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	311,893	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	625,091	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)	360	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,304.98	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	469,793	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/15/2017 10:44 am

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	196,863	2,510,238	0.078424	469,793	36,843	90.00
91.00	Nursing School cost	0	2,510,238	0.000000	469,793	0	91.00
92.00	Allied health cost	0	2,510,238	0.000000	469,793	0	92.00
93.00	All other Medical Education	0	2,510,238	0.000000	469,793	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/15/2017 10:44 am

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		326,500		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.398450	187,044	74,528	50.00
53.00	05300	ANESTHESIOLOGY	0.455815	13,042	5,945	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.364074	36,819	13,405	54.00
54.01	05401	ULTRASOUND	0.091129	136,776	12,464	54.01
56.00	05600	RADIOISOTOPE	0.277114	18,288	5,068	56.00
57.00	05700	CT SCAN	0.034496	102,783	3,546	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.166011	24,024	3,988	58.00
60.00	06000	LABORATORY	0.196553	334,224	65,693	60.00
65.00	06500	RESPIRATORY THERAPY	0.357602	16,487	5,896	65.00
66.00	06600	PHYSICAL THERAPY	0.246676	117,788	29,055	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	0.159489	11,454	1,827	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.176670	69,645	12,304	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.718889	183,118	131,642	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.529647	116,716	61,818	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	75.00
75.01	03951	SLEEP LAB	0.244616	2,002	490	75.01
75.02	03952	WOUND CENTER	0.444024	0	0	75.02
76.00	03953	CARDIAC REHAB	0.683898	0	0	76.00
76.01	03030	DIABETES EDUCATION	2.641879	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.368601	111	41	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.111220	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,370,321	427,710	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)		1,370,321		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1349 | Component CCN: 14-Z349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/15/2017 10:44 am

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	0.398450	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.455815	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.364074	9,794	3,566	54.00
54.01	05401	ULTRASOUND	0.091129	12,259	1,117	54.01
56.00	05600	RADIOISOTOPE	0.277114	0	0	56.00
57.00	05700	CT SCAN	0.034496	22,863	789	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.166011	2,558	425	58.00
60.00	06000	LABORATORY	0.196553	88,130	17,322	60.00
65.00	06500	RESPIRATORY THERAPY	0.357602	3,210	1,148	65.00
66.00	06600	PHYSICAL THERAPY	0.246676	208,039	51,318	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	0.159489	1,932	308	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.176670	13,847	2,446	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.718889	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.529647	65,420	34,650	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	75.00
75.01	03951	SLEEP LAB	0.244616	58	14	75.01
75.02	03952	WOUND CENTER	0.444024	0	0	75.02
76.00	03953	CARDIAC REHAB	0.683898	0	0	76.00
76.01	03030	DIABETES EDUCATION	2.641879	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.368601	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.111220	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		428,110	113,103	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)		428,110		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1349	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/15/2017 10:44 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,023,041	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)	5,023,041	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)	5,073,271	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)	56,193	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,172,450	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,844,628	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,844,628	30.00
31.00	Primary payer payments	1,702	31.00
32.00	Subtotal (line 30 minus line 31)	1,842,926	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)	350,121	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	227,579	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	338,293	36.00
37.00	Subtotal (see instructions)	2,070,505	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)	2,070,505	40.00
40.01	Sequestration adjustment (see instructions)	41,410	40.01
41.00	Interim payments	2,361,590	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-332,495	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 11/15/2017 10:44 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,006,037		2,558,481	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	02/02/2017	4,530		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	06/29/2017	30,652	02/02/2017	128,589	3.50
3.51			0	06/29/2017	68,302	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)		-26,122		-196,891	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)		979,915		2,361,590	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		75,897		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		332,495	6.02
7.00	Total Medicare program liability (see instructions)		1,055,812		2,029,095	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1349 | Component CCN: 14-Z349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/15/2017 10:44 am

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		665,286		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	02/02/2017	12,250		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	06/29/2017	18,349		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)		-6,099		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)		659,187		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		65,324		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		724,511		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1349	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 11/15/2017 10:44 am
	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	372	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	653	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	73	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	953	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	65,932,961	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	14,398	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1349 | Component CCN: 14-Z349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-2 | Date/Time Prepared: 11/15/2017 10:44 am

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)	631,342	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)	114,234	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	479	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)	745,576	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	745,576	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)	745,576	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,279	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)	739,297	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)	739,297	0	19.00
19.01	Sequestration adjustment (see instructions)	14,786	0	19.01
20.00	Interim payments	659,187	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)	65,324	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-3 Part V Date/Time Prepared: 11/15/2017 10:44 am

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,279,868	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)	1,279,868	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,292,667	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)	1,292,667	19.00
20.00	Deductibles (exclude professional component)	227,202	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,065,465	22.00
23.00	Coinsurance	3,612	23.00
24.00	Subtotal (line 22 minus line 23)	1,061,853	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	23,856	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	15,506	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	20,248	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,077,359	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)	1,077,359	30.00
30.01	Sequestration adjustment (see instructions)	21,547	30.01
31.00	Interim payments	979,915	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)	75,897	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

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

Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G | Date/Time Prepared: 11/15/2017 10:44 am

		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	7,299,546	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	7,748,504	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	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	1,238,068	0	0	0	8.00
9.00	Other current assets	589,837	0	0	0	9.00
10.00	Due from other funds	41,711	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	17,124,666	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	326,334	0	0	0	12.00
13.00	Land improvements	855,416	0	0	0	13.00
14.00	Accumulated depreciation	-672,447	0	0	0	14.00
15.00	Buildings	17,042,609	0	0	0	15.00
16.00	Accumulated depreciation	-12,247,188	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	13,021,378	0	0	0	23.00
24.00	Accumulated depreciation	-9,744,732	0	0	0	24.00
25.00	Minor equipment depreciable	129,239	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	246,079	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	8,979,703	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,302,573	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)	2,302,573	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	28,406,942	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	903,925	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,011,819	0	0	0	38.00
39.00	Payroll taxes payable	1,296,382	0	0	0	39.00
40.00	Notes and loans payable (short term)	487,473	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)	3,699,599	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,327,386	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)	2,327,386	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	6,026,985	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	22,379,957				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)	22,379,957	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	28,406,942	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-1 | Date/Time Prepared: 11/15/2017 10:44 am

		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		21,316,918		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,063,039				2.00
3.00	Total (sum of line 1 and line 2)		22,379,957		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)		22,379,957		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)		22,379,957		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: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/15/2017 10:44 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,166,278		1,166,278	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	85,400		85,400	5.00
6.00	Swing bed - NF	700		700	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)	1,252,378		1,252,378	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)	1,252,378		1,252,378	17.00
18.00	Ancillary services	2,755,147	47,043,054	49,798,201	18.00
19.00	Outpatient services	49,207	6,679,132	6,728,339	19.00
20.00	RURAL HEALTH CLINIC	0	7,327,779	7,327,779	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,877,184	1,877,184	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	57,454	886,973	944,427	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,114,186	63,814,122	67,928,308	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,251,293		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)		33,251,293		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-3 Date/Time Prepared: 11/15/2017 10:44 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	67,928,308	1.00
2.00	Less contractual allowances and discounts on patients' accounts	37,371,499	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,556,809	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,251,293	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,694,484	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	223,251	6.00
7.00	Income from investments	125,070	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	44,838	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	2,394	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	172,722	22.00
23.00	Governmental appropriations	255,338	23.00
24.00	OTHER MISC REVENUE	822,483	24.00
24.01	340B CONTRACT PAHARMACY REVENUE	2,111,427	24.01
25.00	Total other income (sum of lines 6-24)	3,757,523	25.00
26.00	Total (line 5 plus line 25)	1,063,039	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,063,039	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1349 | HHA CCN: 14-7694 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H | Date/Time Prepared: 11/15/2017 10:44 am

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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	25,999	25,999	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	268,223	0	0	0	105,003	373,226	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	199,866	0	0	0	0	199,866	6.00
7.00	Physical Therapy	114,112	0	0	0	0	114,112	7.00
8.00	Occupational Therapy	0	0	0	15,334	0	15,334	8.00
9.00	Speech Pathology	0	0	0	18,990	0	18,990	9.00
10.00	Medical Social Services	0	0	0	300	0	300	10.00
11.00	Home Health Aide	1,162	0	0	0	0	1,162	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	583,363	0	0	34,624	131,002	748,989	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	25,999	0	25,999	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	-27,348	345,878	0	345,878	5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	0	199,866	0	199,866	6.00
7.00	Physical Therapy	0	114,112	0	114,112	7.00
8.00	Occupational Therapy	0	15,334	0	15,334	8.00
9.00	Speech Pathology	0	18,990	0	18,990	9.00
10.00	Medical Social Services	0	300	0	300	10.00
11.00	Home Health Aide	0	1,162	0	1,162	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	-27,348	721,641	0	721,641	24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST	Provider CCN: 14-1349 HHA CCN: 14-7694	Period: From 07/01/2016 To 06/30/2017	Worksheet H-1 Part I Date/Time Prepared: 11/15/2017 10:44 am
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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	25,999	0	0	25,999		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	345,878	0	0	25,999	0	371,877	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	199,866	0	0	0	0	199,866	6.00
7.00	Physical Therapy	114,112	0	0	0	0	114,112	7.00
8.00	Occupational Therapy	15,334	0	0	0	0	15,334	8.00
9.00	Speech Pathology	18,990	0	0	0	0	18,990	9.00
10.00	Medical Social Services	300	0	0	0	0	300	10.00
11.00	Home Health Aide	1,162	0	0	0	0	1,162	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	721,641	0	0	25,999	0	721,641	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	371,877		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	212,502	412,368	6.00
7.00	Physical Therapy	121,327	235,439	7.00
8.00	Occupational Therapy	16,303	31,637	8.00
9.00	Speech Pathology	20,191	39,181	9.00
10.00	Medical Social Services	319	619	10.00
11.00	Home Health Aide	1,235	2,397	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		721,641	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-1349 | HHA CCN: 14-7694 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-1 Part II | Date/Time Prepared: 11/15/2017 10:44 am

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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	-371,877	349,764	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	199,866	6.00
7.00	Physical Therapy	0	0	0	0	0	114,112	7.00
8.00	Occupational Therapy	0	0	0	0	0	15,334	8.00
9.00	Speech Pathology	0	0	0	0	0	18,990	9.00
10.00	Medical Social Services	0	0	0	0	0	300	10.00
11.00	Home Health Aide	0	0	0	0	0	1,162	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	1,641	0	-371,877	349,764	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	25,999	0		371,877	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	15.843388	0.000000		1.063223	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS | Provider CCN: 14-1349 | HHA CCN: 14-7694 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-2 Part I | Date/Time Prepared: 11/15/2017 10:44 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	1.01	2.00	4.00	4A	
1.00	Administrative and General	0	13,515	0	6,646	64,412	84,573	1.00
2.00	Skilled Nursing Care	412,368	0	0	0	51,216	463,584	2.00
3.00	Physical Therapy	235,439	0	0	0	29,241	264,680	3.00
4.00	Occupational Therapy	31,637	0	0	0	0	31,637	4.00
5.00	Speech Pathology	39,181	0	0	0	0	39,181	5.00
6.00	Medical Social Services	619	0	0	0	0	619	6.00
7.00	Home Health Aide	2,397	0	0	0	298	2,695	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	721,641	13,515	0	6,646	145,167	886,969	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	22,133	7,854	24,065	0	2,807	0	1.00
2.00	Skilled Nursing Care	121,322	0	0	0	0	0	2.00
3.00	Physical Therapy	69,267	0	0	0	0	0	3.00
4.00	Occupational Therapy	8,279	0	0	0	0	0	4.00
5.00	Speech Pathology	10,254	0	0	0	0	0	5.00
6.00	Medical Social Services	162	0	0	0	0	0	6.00
7.00	Home Health Aide	705	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	232,122	7,854	24,065	0	2,807	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1349 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-2 Part I

HHA CCN: 14-7694 | Date/Time Prepared: 11/15/2017 10:44 am

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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	1,939	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
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,939	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	143,371	0	143,371				1.00
2.00	Skilled Nursing Care	584,906	0	584,906	82,832	667,738		2.00
3.00	Physical Therapy	333,947	0	333,947	47,293	381,240		3.00
4.00	Occupational Therapy	39,916	0	39,916	5,653	45,569		4.00
5.00	Speech Pathology	49,435	0	49,435	7,001	56,436		5.00
6.00	Medical Social Services	781	0	781	111	892		6.00
7.00	Home Health Aide	3,400	0	3,400	481	3,881		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
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	1,155,756	0	1,155,756	143,371	1,155,756		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.				0.141617			21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1349 | HHA CCN: 14-7694 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-2 Part II | Date/Time Prepared: 11/15/2017 10:44 am

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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	6,524	251,365	0	84,573	1.00
2.00	Skilled Nursing Care	0	0	0	199,866	0	463,584	2.00
3.00	Physical Therapy	0	0	0	114,112	0	264,680	3.00
4.00	Occupational Therapy	0	0	0	0	0	31,637	4.00
5.00	Speech Pathology	0	0	0	0	0	39,181	5.00
6.00	Medical Social Services	0	0	0	0	0	619	6.00
7.00	Home Health Aide	0	0	0	1,162	0	2,695	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,641	0	6,524	566,505		886,969	20.00
21.00	Total cost to be allocated	13,515	0	6,646	145,167		232,122	21.00
22.00	Unit cost multiplier	8.235832	0.000000	1.018700	0.256250		0.261702	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	1,641	0	1,025	0	13	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,641	1,641	0	1,025	0	13	20.00
21.00	Total cost to be allocated	7,854	24,065	0	2,807	0	1,939	21.00
22.00	Unit cost multiplier	4.786106	14.664839	0.000000	2.738537	0.000000	149.153846	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1349 | HHA CCN: 14-7694 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-2 Part II | Date/Time Prepared: 11/15/2017 10:44 am

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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
19.50	Telemedicine	0	0	0	0	0		19.50
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: 14-1349 | HHA CCN: 14-7694 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-3 Part I | Date/Time Prepared: 11/15/2017 10:44 am

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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	667,738		667,738	3,713	179.84	1.00
2.00	Physical Therapy	3.00	381,240	0	381,240	3,594	106.08	2.00
3.00	Occupational Therapy	4.00	45,569	0	45,569	224	203.43	3.00
4.00	Speech Pathology	5.00	56,436	0	56,436	158	357.19	4.00
5.00	Medical Social Services	6.00	892		892	6	148.67	5.00
6.00	Home Health Aide	7.00	3,881		3,881	37	104.89	6.00
7.00	Total (sum of lines 1-6)		1,155,756	0	1,155,756	7,732		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	1,987			8.00
8.01	Skilled Nursing Care		41180	0	129			8.01
8.02	Skilled Nursing Care		16060	0	82			8.02
9.00	Physical Therapy		99914	0	2,364			9.00
9.01	Physical Therapy		41180	0	144			9.01
9.02	Physical Therapy		16060	0	68			9.02
10.00	Occupational Therapy		99914	0	117			10.00
10.01	Occupational Therapy		41180	0	4			10.01
10.02	Occupational Therapy		16060	0	9			10.02
11.00	Speech Pathology		99914	0	107			11.00
11.01	Speech Pathology		41180	0	3			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	5,023			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	2,616	2,616	14,808	0.176661	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	2,198		0	395,288		1.00
2.00	Physical Therapy	0	2,576		0	273,262		2.00
3.00	Occupational Therapy	0	130		0	26,446		3.00
4.00	Speech Pathology	0	110		0	39,291		4.00
5.00	Medical Social Services	0	1		0	149		5.00
6.00	Home Health Aide	0	8		0	839		6.00
7.00	Total (sum of lines 1-6)	0	5,023		0	735,275		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-1349 | HHA CCN: 14-7694 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-3 Part I | Date/Time Prepared: 11/15/2017 10:44 am

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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

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	395,288	1.00
2.00	Physical Therapy	273,262	2.00
3.00	Occupational Therapy	26,446	3.00
4.00	Speech Pathology	39,291	4.00
5.00	Medical Social Services	149	5.00
6.00	Home Health Aide	839	6.00
7.00	Total (sum of lines 1-6)	735,275	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: 14-1349
HHA CCN: 14-7694
Period: From 07/01/2016 To 06/30/2017
Worksheet H-3 Part II
Date/Time Prepared: 11/15/2017 10:44 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.246676	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	0.176670	14,808	2,616	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.529647	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1349 | HHA CCN: 14-7694 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-4 Part I-II | Date/Time Prepared: 11/15/2017 10:44 am

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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	913,349	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	12,257	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	6,358	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	11,555	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	943,519	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	943,519	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	943,519	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	943,519	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	943,519	31.00
31.01	Sequestration adjustment (see instructions)	0	18,870	31.01
32.00	Interim payments (see instructions)	0	924,649	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 HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1349 HHA CCN: 14-7694	Period: From 07/01/2016 To 06/30/2017	Worksheet H-5 Date/Time Prepared: 11/15/2017 10:44 am
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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		924,649	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		924,649	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		924,649	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1349 | Component CCN: 14-3464 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/15/2017 10:44 am

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	2,058,897	695,898	2,754,795	-8,750	2,746,045	1.00
2.00	Physician Assistant	310,902	0	310,902	0	310,902	2.00
3.00	Nurse Practitioner	518,143	49,775	567,918	0	567,918	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,213,005	0	1,213,005	0	1,213,005	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	8,174	8,174	0	8,174	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)	4,100,947	753,847	4,854,794	-8,750	4,846,044	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	493,591	493,591	0	493,591	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	136,741	136,741	0	136,741	18.00
19.00	Other Health Care Costs	0	31,066	31,066	0	31,066	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	661,398	661,398	0	661,398	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	4,100,947	1,415,245	5,516,192	-8,750	5,507,442	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	97,815	97,815	-21,187	76,628	29.00
30.00	Administrative Costs	423,926	167,773	591,699	21,986	613,685	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	423,926	265,588	689,514	799	690,313	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,524,873	1,680,833	6,205,706	-7,951	6,197,755	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1349 | Component CCN: 14-3464 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/15/2017 10:44 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	-78,132	2,667,913	1.00
2.00	Physician Assistant	-1,013	309,889	2.00
3.00	Nurse Practitioner	0	567,918	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	1,213,005	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	8,174	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)	-79,145	4,766,899	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	493,591	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	136,741	18.00
19.00	Other Health Care Costs	0	31,066	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	661,398	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-79,145	5,428,297	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	76,628	29.00
30.00	Administrative Costs	0	613,685	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	690,313	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-79,145	6,118,610	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1349 | Component CCN: 14-3464 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-2 | Date/Time Prepared: 11/15/2017 10:44 am

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	7.32	25,426	4,200	30,744		1.00
2.00	Physician Assistant	2.60	8,104	2,100	5,460		2.00
3.00	Nurse Practitioner	4.91	15,787	2,100	10,311		3.00
4.00	Subtotal (sum of lines 1 through 3)	14.83	49,317		46,515	49,317	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	0.17	185			185	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)	15.00	49,502			49,502	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	5,428,297	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	5,428,297	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	690,313	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	4,216,993	15.00
16.00	Total overhead (sum of lines 14 and 15)	4,907,306	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	4,907,306	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	4,907,306	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	10,335,603	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1349 Component CCN: 14-3464	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/15/2017 10:44 am
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		10,335,603	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		361,465	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		9,974,138	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		49,502	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)		49,502	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		201.49	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30	8.00
9.00	Rate for Program covered visits (see instructions)	201.49	201.49	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	6,561	6,561	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	1,321,976	1,321,976	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	2,643,952	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,672,028	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		74,425	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		117,688	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.)		1,925,158	16.04
16.05	Total program cost (see instructions)	0	2,042,846	16.05
17.00	Primary payer amounts		41	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		119,817	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		295,557	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		2,042,805	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		136,722	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		2,179,527	22.00
23.00	Allowable bad debts (see instructions)		75,544	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		49,104	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		74,979	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)		2,228,631	26.00
26.01	Sequestration adjustment (see instructions)		44,573	26.01
27.00	Interim payments		1,776,398	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)		407,660	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-1349 Component CCN: 14-3464	Period: From 07/01/2016 To 06/30/2017	Worksheet M-4 Date/Time Prepared: 11/15/2017 10:44 am
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	4,766,899	4,766,899	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000761	0.001790	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	3,628	8,533	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	131,773	45,908	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	135,401	54,441	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	5,428,297	5,428,297	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	4,907,306	4,907,306	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.024944	0.010029	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	122,408	49,215	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	257,809	103,656	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	849	1,996	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	303.66	51.93	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	329	709	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	99,904	36,818	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)		361,465	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)		136,722	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1349 Component CCN: 14-3464	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/15/2017 10:44 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,724,782	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		02/02/2017	51,616	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)		51,616	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,776,398	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		407,660	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		2,184,058	7.00

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