

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 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 7/18/2017 10:39 am
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PART I - COST REPORT STATUS

Provider use only

1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. 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. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 7/18/2017 Time: 10:39 am

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 07/01/2015 and ending 06/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____ Title

_____ Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-32,530	-84,526	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	-29,210	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		-2,023		0	10.00
200.00 Total	0	-61,740	-86,549	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-MEDI-CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1349			Period: From 07/01/2015 To 06/30/2016		Worksheet S-2 Part I Date/Time Prepared: 7/18/2017 10:36 am						
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IL Zip Code: 62286		4.00 County: RANDOLPH							
1.00 Street: 818 EAST BROADWAY		2.00 City: SPARTA											
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00			
3.00 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 - FOHC										16.00		
17.00	Hospital-Based (CMHC) I										17.00		
18.00	Renal Dialysis										18.00		
19.00	Other										19.00		
							From:	To:					
							1.00	2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2015	06/30/2016		20.00			
21.00	Type of Control (see instructions)						11			21.00			
Inpatient PPS Information													
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N	N		22.00			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	N		22.01			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03			
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							3	N		23.00		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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	0	25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1349	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 7/18/2017 10:36 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.		0			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	XVII	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	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	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	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		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
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	0.00	0.00				61.06
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00	2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00		61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00		61.20
					1.00		
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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				
64.00	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. 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

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		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
				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
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
				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		
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		
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		
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.			N		
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		
				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	
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	
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		
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	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	

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		V 1.00	XIX 2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	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	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	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. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	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 1.00	Occupational 2.00	Speech 3.00	Respiratory 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 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	429,051	0		0	118.01
					1.00	
					2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1349	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 7/18/2017 10:36 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			
165.00	Multi campus Is this hospital part of a Multi campus 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
				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	
168.01	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1349	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 7/18/2017 10:36 am
		Beginning 1.00	Ending 2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2015	09/30/2015	170.00
		1.00	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. 1, 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		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1349		Period: From 07/01/2015 To 06/30/2016		Worksheet S-2 Part II Date/Time Prepared: 7/18/2017 10:36 am	
		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				
		1.00	2.00				
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				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N	N				6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/03/2016	Y	10/03/2016		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1349	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 7/18/2017 10:36 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 relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATTY		RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544		211 N BROADWAY STE 600, ST LOUIS, MO	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1349	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 7/18/2017 10:36 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.	DI RECTOR		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 07/01/2015
To 06/30/2016

Worksheet S-3
Part I
Date/Time Prepared:
7/18/2017 10:36 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / T r i p s	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	22,767.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	22,767.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,150	22,767.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				4,034	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	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 07/01/2015
To 06/30/2016

Worksheet S-3
Part I
Date/Time Prepared:
7/18/2017 10:36 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)	626	68	956			1.00
2.00 HMO and other (see instructions)	28	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	549	0	549			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	206			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,175	68	1,711			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	1,175	68	1,711	0.00	180.93	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	7,796	0.00	10.43	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	23			24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	11,934	0	46,814	0.00	64.76	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	256.12	27.00
28.00 Observation Bed Days		92	553			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			2			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1349

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

Worksheet S-3
Part I
Date/Time Prepared:
7/18/2017 10:36 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	239	32	344	1.00
2.00 HMO and other (see instructions)				11	0		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		239	32	344	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY	0.00						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RHC (CONSOLIDATED)	0.00						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	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 07/01/2015 To 06/30/2016	Worksheet S-4 Date/Time Prepared: 7/18/2017 10:36 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	276.00	42.00	109.00	427.00	2.00
		Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week			Staff	Contract	Total
		0	1.00	2.00	3.00		
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00					3.00
4.00	Director(s) and Assistant Director(s)	0.00					4.00
5.00	Other Administrative Personnel	3.56					5.00
6.00	Direct Nursing Service	4.33					6.00
7.00	Nursing Supervisor	0.00					7.00
8.00	Physical Therapy Service	2.50					8.00
9.00	Physical Therapy Supervisor	0.00					9.00
10.00	Occupational Therapy Service	0.00					10.00
11.00	Occupational Therapy Supervisor	0.00					11.00
12.00	Speech Pathology Service	0.00					12.00
13.00	Speech Pathology Supervisor	0.00					13.00
14.00	Medical Social Service	0.00					14.00
15.00	Medical Social Service Supervisor	0.00					15.00
16.00	Home Health Aide	0.01					16.00
17.00	Home Health Aide Supervisor	0.00					17.00
18.00	Other (specify)	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		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,817	16	42	40	1,915	21.00
22.00	Skilled Nursing Visit Charges	483,433	4,206	12,054	10,925	510,618	22.00
23.00	Physical Therapy Visits	1,926	24	12	55	2,017	23.00
24.00	Physical Therapy Visit Charges	411,433	5,035	3,595	11,803	431,866	24.00
25.00	Occupational Therapy Visits	58	8	0	0	66	25.00
26.00	Occupational Therapy Visit Charges	12,366	16,206	0	0	28,572	26.00
27.00	Speech Pathology Visits	27	0	0	0	27	27.00
28.00	Speech Pathology Visit Charges	7,243	0	0	0	7,243	28.00
29.00	Medical Social Service Visits	1	0	0	0	1	29.00
30.00	Medical Social Service Visit Charges	391	0	0	0	391	30.00
31.00	Home Health Aide Visits	8	0	0	0	8	31.00
32.00	Home Health Aide Visit Charges	1,188	0	0	0	1,188	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,837	48	54	95	4,034	33.00
34.00	Other Charges	18,153	24	234	64	18,475	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	934,207	25,471	15,883	22,792	998,353	35.00
36.00	Total Number of Episodes (standard/non outlier)	234		18	8	260	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1349 Component CCN: 14-3464	Period: From 07/01/2015 To 06/30/2016	Worksheet S-8 Date/Time Prepared: 7/18/2017 10:36 am	
		RHC I	Cost		
		1.00			
1.00	Clinic Address and Identification 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
		1.00	2.00	3.00	4.00
11.00	Facility hours of operations (1) Clinic	09:00	14:00	09:00	19:00
		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
		1.00	2.00	3.00	4.00
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)				
		County			
		4.00			
2.00	City, State, ZIP Code, County	RANDOLPH			2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1349
Component CCN: 14-3464

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

Worksheet S-8

Date/Time Prepared:
7/18/2017 10:36 am

		RHC I		Cost		
		Tuesday	Wednesday	Thursday		
		to	from to	from	to	
		6.00	7.00 8.00	9.00	10.00	
11.00	Facility hours of operations (1) Clinic	19:00	09:00	19:00	09:00	19:00
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
11.00	Facility hours of operations (1) Clinic	09:00	19:00	09:00	16:00	11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1349	Period: From 07/01/2015 To 06/30/2016	Worksheet S-10 Date/Time Prepared: 7/18/2017 10:36 am
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			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)		0.407090	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		3,361,909	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		2,210,212	5.00
6.00	Medicaid charges		11,457,351	6.00
7.00	Medicaid cost (line 1 times line 6)		4,664,173	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
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		15,200	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		75,432	18.00
19.00	Total unreimbursed cost for Medicaid, 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
20.00	Charity care charges for the entire facility (see instructions)	63,830	0	63,830
21.00	Cost of patients approved for charity care (line 1 times line 20)	25,985	0	25,985
22.00	Partial payment by patients approved for charity care	20,680	0	20,680
23.00	Cost of charity care (line 21 minus line 22)	5,305	0	5,305
				1.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,986,646	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		293,059	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		2,693,587	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,096,532	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,101,837	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,101,837	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 14-1349		Period: From 07/01/2015 To 06/30/2016		Worksheet A	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		750,507	750,507	-42,847	707,660	1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG		0	0	188,550	188,550	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,319,543	1,319,543	26,295	1,345,838	2.00
3.00	00300	OTHER CAP RELATED COST		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,532,839	3,532,839	0	3,532,839	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,747,364	2,721,570	5,468,934	-103,407	5,365,527	5.00
6.00	00600	MAINTENANCE & REPAIRS	195,294	11,718	207,012	0	207,012	6.00
7.00	00700	OPERATION OF PLANT	0	448,196	448,196	66,537	514,733	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	46,237	46,237	0	46,237	8.00
9.00	00900	HOUSEKEEPING	220,663	137,222	357,885	0	357,885	9.00
10.00	01000	DIETARY	148,526	117,515	266,041	36,812	302,853	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	118,379	3,998	122,377	0	122,377	13.00
15.00	01500	PHARMACY	0	1,594,442	1,594,442	0	1,594,442	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	285,467	55,644	341,111	0	341,111	16.00
17.00	01700	SOCIAL SERVICE	39,952	769	40,721	0	40,721	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	588,744	588,744	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	979,104	554,773	1,533,877	-13,790	1,520,087	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	543,001	845,254	1,388,255	-388,424	999,831	50.00
53.00	05300	ANESTHESIOLOGY	223,173	419,084	642,257	-597,525	44,732	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	449,655	198,981	648,636	-63,265	585,371	54.00
54.01	05401	ULTRASOUND	95,993	57,536	153,529	135	153,664	54.01
56.00	05600	RADIOISOTOPE	0	378,286	378,286	4,546	382,832	56.00
57.00	05700	CT SCAN	0	108,153	108,153	40,674	148,827	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	37,418	37,418	22,591	60,009	58.00
60.00	06000	LABORATORY	493,795	892,200	1,385,995	-11,725	1,374,270	60.00
65.00	06500	RESPIRATORY THERAPY	48,185	33,403	81,588	0	81,588	65.00
66.00	06600	PHYSICAL THERAPY	594,885	97,125	692,010	-27,286	664,724	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	26,236	2,755	28,991	7,044	36,035	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,030	6,030	126,364	132,394	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	320,382	320,382	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	120,700	120,700	0	120,700	75.01
75.02	03952	WOUND CENTER	0	68,819	68,819	0	68,819	75.02
76.00	03953	CARDIAC REHAB	86,877	6,235	93,112	0	93,112	76.00
76.01	03030	DIABETES EDUCATION	81,717	5,559	87,276	-36,812	50,464	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,870,530	1,511,993	5,382,523	28,336	5,410,859	88.00
91.00	09100	EMERGENCY	675,280	1,082,500	1,757,780	-35,751	1,722,029	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	578,816	163,588	742,404	-9,142	733,262	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		114,212	114,212	-114,212	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,502,892	17,444,804	29,947,696	12,824	29,960,520	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	472,761	130,392	603,153	-11,536	591,617	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	0	0	-1,288	-1,288	194.01
200.00		TOTAL (SUM OF LINES 118-199)	12,975,653	17,575,196	30,550,849	0	30,550,849	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1349

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

Worksheet A
Date/Time Prepared:
7/18/2017 10:36 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	-43,479	664,181	1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	13,381	201,931	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-141,481	1,204,357	2.00
3.00	00300	OTHER CAP RELATED COST	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-604,896	2,927,943	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-672,461	4,693,066	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	207,012	6.00
7.00	00700	OPERATION OF PLANT	0	514,733	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	46,237	8.00
9.00	00900	HOUSEKEEPING	0	357,885	9.00
10.00	01000	DIETARY	-41,373	261,480	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	122,377	13.00
15.00	01500	PHARMACY	-591,739	1,002,703	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,917	338,194	16.00
17.00	01700	SOCIAL SERVICE	0	40,721	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-588,744	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-411,016	1,109,071	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	999,831	50.00
53.00	05300	ANESTHESIOLOGY	0	44,732	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	-1,386	583,985	54.00
54.01	05401	ULTRASOUND	0	153,664	54.01
56.00	05600	RADIOISOTOPE	0	382,832	56.00
57.00	05700	CT SCAN	0	148,827	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	60,009	58.00
60.00	06000	LABORATORY	0	1,374,270	60.00
65.00	06500	RESPIRATORY THERAPY	0	81,588	65.00
66.00	06600	PHYSICAL THERAPY	0	664,724	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	36,035	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-6	132,388	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	320,382	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	75.00
75.01	03951	SLEEP LAB	0	120,700	75.01
75.02	03952	WOUND CENTER	0	68,819	75.02
76.00	03953	CARDIAC REHAB	0	93,112	76.00
76.01	03030	DIABETES EDUCATION	0	50,464	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-67,068	5,343,791	88.00
91.00	09100	EMERGENCY	-325,697	1,396,332	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	733,262	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,478,882	26,481,638	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
194.00	07950	FREESTANDING CLINICS	0	591,617	194.00
194.01	07951	THE CENTER - FITNESS CENTER	76,231	74,943	194.01
200.00		TOTAL (SUM OF LINES 118-199)	-3,402,651	27,148,198	200.00

RECLASSIFICATIONS

Provider CCN: 14-1349

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

Worksheet A-6

Date/Time Prepared:
7/18/2017 10:36 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	126,364	1.00	
2.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	320,382	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
	O		0	446,746		
B - TO RECLASS INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	113,071	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,141	2.00	
	O		0	114,212		
C - TO RECLASS EKG SALARIES						
1.00	ELECTROCARDIOLOGY	69.00	11,725	0	1.00	
	O		11,725	0		
D - TO RECLASS PROPERTY INSURANCE						
1.00	OTHER CAP RELATED COST	3.00	0	58,927	1.00	
	O		0	58,927		
E - TO RECLASS TELEPHONE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,030	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
	O		0	16,030		
G - TO RECLASS CRNA EXPENSES						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	223,173	365,571	1.00	
	O		223,173	365,571		
H - TO RECLASS NORTHCAMPUS BLDG						
1.00	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	182,535	1.00	
	O		0	182,535		
I - TO RECLASS CT SCAN						
1.00	CT SCAN	57.00	40,674	0	1.00	
	O		40,674	0		
J - TO RECLASS RECRUITMENT EXPENSE						
1.00	RURAL HEALTH CLINIC	88.00	0	61,651	1.00	
	O		0	61,651		
K - TO RECLASS STRESS TEST SALARIES						
1.00	RADIOISOTOPE	56.00	4,546	0	1.00	
2.00	ULTRASOUND	54.01	135	0	2.00	
	O		4,681	0		
L - TO RECLASS MRI SALARIES						
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	22,591	0	1.00	
	O		22,591	0		
M - TO RECLASS DIETARY SALARIES						
1.00	DIETARY	10.00	36,812	0	1.00	
	TOTALS		36,812	0		
O - UTILITY EXPENSE						
1.00	OPERATION OF PLANT	7.00	0	66,537	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	
	TOTALS		0	66,537		
500.00	Grand Total: Increases		339,656	1,312,209	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1349

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

Worksheet A-6

Date/Time Prepared:
7/18/2017 10:36 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	388,424	0	1.00	
2.00	ADULTS & PEDIATRICS	30.00	0	13,790	0	2.00	
3.00	ANESTHESIOLOGY	53.00	0	8,781	0	3.00	
4.00	EMERGENCY	91.00	0	35,751	0	4.00	
	O		0	446,746			
B - TO RECLASS INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	114,212	11	1.00	
2.00		0.00	0	0	11	2.00	
	O		0	114,212			
C - TO RECLASS EKG SALARIES							
1.00	LABORATORY	60.00	11,725	0	0	1.00	
	O		11,725	0			
D - TO RECLASS PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	58,927	12	1.00	
	O		0	58,927			
E - TO RECLASS TELEPHONE EXPENSE							
1.00	PHYSICAL THERAPY	66.00	0	379	0	1.00	
2.00	RURAL HEALTH CLINIC	88.00	0	14,425	0	2.00	
3.00	FREESTANDING CLINICS	194.00	0	1,226	0	3.00	
	O		0	16,030			
G - TO RECLASS CRNA EXPENSES							
1.00	ANESTHESIOLOGY	53.00	223,173	365,571	0	1.00	
	O		223,173	365,571			
H - TO RECLASS NORTHCAMPUS BLDG							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	182,535	9	1.00	
	O		0	182,535			
I - TO RECLASS CT SCAN							
1.00	RADIOLOGY - DIAGNOSTIC	54.00	40,674	0	0	1.00	
	O		40,674	0			
J - TO RECLASS RECRUITMENT EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	61,651	0	1.00	
	O		0	61,651			
K - TO RECLASS STRESS TEST SALARIES							
1.00	ELECTROCARDIOLOGY	69.00	4,681	0	0	1.00	
2.00		0.00	0	0	0	2.00	
	O		4,681	0			
L - TO RECLASS MRI SALARIES							
1.00	RADIOLOGY - DIAGNOSTIC	54.00	22,591	0	0	1.00	
	O		22,591	0			
M - TO RECLASS DIETARY SALARIES							
1.00	DIABETES EDUCATION	76.01	36,812	0	0	1.00	
	TOTALS		36,812	0			
O - UTILITY EXPENSE							
1.00	PHYSICAL THERAPY	66.00	0	26,907	0	1.00	
2.00	RURAL HEALTH CLINIC	88.00	0	18,890	0	2.00	
3.00	THE CENTER - FITNESS CENTER	194.01	0	1,288	0	3.00	
4.00	FREESTANDING CLINICS	194.00	0	10,310	0	4.00	
5.00	HOME HEALTH AGENCY	101.00	0	9,142	0	5.00	
	TOTALS		0	66,537			
500.00	Grand Total: Decreases		339,656	1,312,209		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1349

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

Worksheet A-7
Part I
Date/Time Prepared:
7/18/2017 10:36 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	236,334	0	0	0	1.00
2.00	Land Improvements	763,834	112,368	0	112,368	2.00
3.00	Buildings and Fixtures	16,500,027	210,677	0	210,677	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	12,796,297	1,097,026	0	1,097,026	6.00
7.00	HIT designated Assets	891,921	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,188,413	1,420,071	0	1,420,071	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	31,188,413	1,420,071	0	1,420,071	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	236,334	0			1.00
2.00	Land Improvements	845,711	0			2.00
3.00	Buildings and Fixtures	16,710,704	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	13,255,564	0			6.00
7.00	HIT designated Assets	891,921	0			7.00
8.00	Subtotal (sum of lines 1-7)	31,940,234	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	31,940,234	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1349

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

Worksheet A-7
Part II
Date/Time Prepared:
7/18/2017 10:36 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	750,507	0	0	0	0	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	1,319,543	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,070,050	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	750,507		1.00		
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0		1.01		
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,319,543		2.00		
3.00	Total (sum of lines 1-2)	0	2,070,050		3.00		

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1349

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

Worksheet A-7
Part III
Date/Time Prepared:
7/18/2017 10:36 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	14,320,338	0	14,320,338	0.451690	26,617	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	3,236,076	0	3,236,076	0.102072	6,015	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	14,147,485	0	14,147,485	0.446238	26,295	2.00
3.00	Total (sum of lines 1-2)	31,703,899	0	31,703,899	1.000000	58,927	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col. 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	26,617	567,972	0	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	6,015	195,916	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	26,295	1,178,062	0	2.00
3.00	Total (sum of lines 1-2)	0	0	58,927	1,941,950	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 col. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	69,592	26,617	0	0	664,181	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	6,015	0	0	201,931	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	26,295	0	0	1,204,357	2.00
3.00	Total (sum of lines 1-2)	69,592	58,927	0	0	2,070,469	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1349

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

Worksheet A-8

Date/Time Prepared:
7/18/2017 10:36 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	-43,479	CAP REL COSTS-BLDG & FIXT		1.00	11	1.00
1.01 Investment income - CAP REL COSTS-NORTH CAMPUS BLDG (chapter 2)			OCAP REL COSTS-NORTH CAMPUS BLDG		1.01		1.01
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP		2.00		2.00
3.00 Investment income - other (chapter 2)	B	-439	ADMINISTRATIVE & GENERAL		5.00		3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00		4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-49,983	ADMINISTRATIVE & GENERAL		5.00		5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00		6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00		7.00
8.00 Television and radio service (chapter 21)		0			0.00		8.00
9.00 Parking lot (chapter 21)		0			0.00		9.00
10.00 Provider-based physician adjustment	A-8-2	-790,376					10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00		11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0					12.00
13.00 Laundry and linen service		0			0.00		13.00
14.00 Cafeteria-employees and guests	B	-41,373	DIETARY		10.00		14.00
15.00 Rental of quarters to employee and others		0			0.00		15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-6	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00		16.00
17.00 Sale of drugs to other than patients		0			0.00		17.00
18.00 Sale of medical records and abstracts	B	-2,917	MEDICAL RECORDS & LIBRARY		16.00		18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00		19.00
20.00 Vending machines		0			0.00		20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00		21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00		22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY		65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL 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			OCAP REL COSTS-BLDG & FIXT		1.00		26.00
26.01 Depreciation - CAP REL COSTS-NORTH CAMPUS BLDG			OCAP REL COSTS-NORTH CAMPUS BLDG		1.01		26.01
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			OCAP REL COSTS-MVBLE EQUIP		2.00		27.00
28.00 Non-physician Anesthetist	A	-588,744	NONPHYSICIAN ANESTHETISTS		19.00		28.00
29.00 Physicians' assistant		0			0.00		29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY		67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			OADULTS & PEDIATRICS		30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1349

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

Worksheet A-8

Date/Time Prepared:
7/18/2017 10:36 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center	Line #			
			1.00	2.00	3.00		4.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-139,814	CAP REL COSTS-MVBLE EQUIP		2.00	9	32.00
33.00 BILL COPY CHARGES	B	-9,843	ADMINISTRATIVE & GENERAL		5.00	0	33.00
33.01 MISCELLANEOUS INCOME	B	-9,101	ADMINISTRATIVE & GENERAL		5.00	0	33.01
33.02 TRANSMED SERVICE REVENUE	B	-4,954	ADMINISTRATIVE & GENERAL		5.00	0	33.02
33.03 340B CONTRACT EXPENSES	A	-591,739	PHARMACY		15.00	0	33.03
33.04 PERSONAL USE OF AUTO	A	-5,086	ADMINISTRATIVE & GENERAL		5.00	0	33.04
33.05 CRNA BENEFITS	A	-28,965	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.05
33.06 MARKETING SALARY	A	-38,704	ADMINISTRATIVE & GENERAL		5.00	0	33.06
33.07 MARKETING EXPENSES	A	-134,343	ADMINISTRATIVE & GENERAL		5.00	0	33.07
33.08 MARKETING EMPLOYEE BENEFITS	A	-10,483	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.08
33.09 INSURANCE DIVIDEND	B	-392,384	ADMINISTRATIVE & GENERAL		5.00	0	33.09
33.10 LOBBYING EXPENSES	A	-10,498	ADMINISTRATIVE & GENERAL		5.00	0	33.10
33.11 SELF INSURANCE EXPENSE	A	-534,319	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.11
33.12 SELF INSURANCE EXPENS RHC	A	-64,543	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.12
33.13 HOSPICE CONTRACT REVENUE	B	-10,500	ADULTS & PEDIATRICS		30.00	0	33.13
33.14 USAC SUBSIDY	B	-16,995	ADMINISTRATIVE & GENERAL		5.00	0	33.14
33.15 EMPLOYEE ACTIVITIES	B	-880	ADMINISTRATIVE & GENERAL		5.00	0	33.15
33.16 340B CONTRACT DEPRECIATION	A	-1,667	CAP REL COSTS-MVBLE EQUIP		2.00	9	33.16
33.17 PHYSICIAN RECRUITMENT	A	-4,291	RURAL HEALTH CLINIC		88.00	0	33.17
33.18 THE CENTER EXPENSES	A	76,231	THE CENTER - FITNESS CENTER		194.01	0	33.18
33.19 THE CENTER DEPRECIATION	A	13,381	CAP REL COSTS-NORTH CAMPUS BLDG		1.01	9	33.19
33.20 THE CENTER A&G EXPENSES	A	749	ADMINISTRATIVE & GENERAL		5.00	0	33.20
33.21 THE CENTER BENEFITS	A	33,414	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.21
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,402,651					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 07/01/2015
To 06/30/2016

Worksheet A-8-2

Date/Time Prepared:
7/18/2017 10:36 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	436,516	400,516	36,000	0	0	1.00
2.00	91.00	EMERGENCY	948,799	325,697	623,102	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	24,000	0	24,000	0	0	3.00
4.00	54.00	RADIOLOGY - DIAGNOSTIC	1,386	1,386	0	0	0	4.00
5.00	60.00	LABORATORY	20,400	0	20,400	0	0	5.00
6.00	88.00	RURAL HEALTH CLINIC	62,777	62,777	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,493,878	790,376	703,502	0	0	200.00

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

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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1349		Period: From 07/01/2015 To 06/30/2016		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/18/2017 10:36 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					0	1.00
2.00	Line 1 multiplied by 15 hours per week					0	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	75.07	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.54	37.54	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					169	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					169	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					169	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					169	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1349		Period: From 07/01/2015 To 06/30/2016		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/18/2017 10:36 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)	75.07	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					169	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					169	63.00
64.00	Total cost of outside supplier services (from your records)					135	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					0	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1349		Period: From 07/01/2015 To 06/30/2016		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/18/2017 10:36 am	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					39	1.00
2.00	Line 1 multiplied by 15 hours per week					585	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	278.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.14	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.07	36.07	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					20,091	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					20,091	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					20,091	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					72.14	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					42,202	22.00
23.00	Total salary equivalency (see instructions)					42,202	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1349				Period: From 07/01/2015 To 06/30/2016	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/18/2017 10:36 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	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	0.00	49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.14	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					42,202	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					42,202	63.00
64.00	Total cost of outside supplier services (from your records)					15,870	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					0	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1349

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

Worksheet B
Part I
Date/Time Prepared:
7/18/2017 10:36 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	664,181	664,181			1.00
1.01 00101	CAP REL COSTS-NORTH CAMPUS BLDG	201,931	0	201,931		1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,204,357			1,204,357	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,927,943	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,693,066	63,809	40,891	261,786	2,927,943
6.00 00600	MAINTENANCE & REPAIRS	207,012	31,486	0	498	44,737
7.00 00700	OPERATION OF PLANT	514,733	53,668	5,583	58,620	0
8.00 00800	LAUNDRY & LINEN SERVICE	46,237	4,953	0	0	0
9.00 00900	HOUSEKEEPING	357,885	6,730	0	437	50,548
10.00 01000	DIETARY	261,480	15,489	0	7,149	42,456
11.00 01100	CAFETERIA	0	8,609	0	0	0
13.00 01300	NURSING ADMINISTRATION	122,377	2,885	0	84	27,118
15.00 01500	PHARMACY	1,002,703	4,342	0	1,477	0
16.00 01600	MEDICAL RECORDS & LIBRARY	338,194	14,098	10,169	7,669	65,393
17.00 01700	SOCIAL SERVICE	40,721	0	0	0	9,152
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,109,071	62,531	0	38,800	224,287
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	999,831	58,376	0	88,993	124,387
53.00 05300	ANESTHESIOLOGY	44,732	827	0	292	0
54.00 05400	RADIOLOGY - DIAGNOSTIC	583,985	11,664	0	125,024	88,512
54.01 05401	ULTRASOUND	153,664	3,374	0	36,013	22,020
56.00 05600	RADIOISOTOPE	382,832	2,707	0	0	1,041
57.00 05700	CT SCAN	148,827	3,402	0	113,004	9,317
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	60,009	8,722	0	215,215	5,175
60.00 06000	LABORATORY	1,374,270	16,909	0	31,350	110,430
65.00 06500	RESPIRATORY THERAPY	81,588	1,720	0	5,354	11,038
66.00 06600	PHYSICAL THERAPY	664,724	4,521	43,063	11,816	136,273
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00 06900	ELECTROCARDIOLOGY	36,035	1,635	0	0	7,624
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	132,388	5,367	0	449	0
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	320,382	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
75.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
75.01 03951	SLEEP LAB	120,700	5,339	0	1,226	0
75.02 03952	WOUND CENTER	68,819	13,957	0	0	0
76.00 03953	CARDIAC REHAB	93,112	8,450	0	5,127	19,901
76.01 03030	DIABETES EDUCATION	50,464	1,776	0	0	10,287
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	5,343,791	132,338	60,942	104,435	886,642
91.00 09100	EMERGENCY	1,396,332	28,027	0	55,038	154,689
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	733,262	15,424	0	7,011	132,592
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	26,481,638	593,135	160,648	1,176,867	2,804,110
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,880	0	0	0
194.00 07950	FREESTANDING CLINICS	591,617	69,166	0	16,016	108,297
194.01 07951	THE CENTER - FITNESS CENTER	74,943	0	41,283	11,474	15,536
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	27,148,198	664,181	201,931	1,204,357	2,927,943

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1349

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

Worksheet B Part I Date/Time Prepared: 7/18/2017 10:36 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	5,680,043	5,680,043				5.00
6.00	00600	MAINTENANCE & REPAIRS	283,733	75,070	358,803			6.00
7.00	00700	OPERATION OF PLANT	632,604	167,374	26,897	826,875		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	51,190	13,544	2,482	7,053	74,269	8.00
9.00	00900	HOUSEKEEPING	415,600	109,959	3,373	9,582		9.00
10.00	01000	DIETARY	326,574	86,405	7,763	22,055	37	10.00
11.00	01100	CAFETERIA	8,609	2,278	4,315	12,259	0	11.00
13.00	01300	NURSING ADMINISTRATION	152,464	40,339	1,446	4,108	0	13.00
15.00	01500	PHARMACY	1,008,522	266,835	2,176	6,183	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	435,523	115,231	13,552	38,502	0	16.00
17.00	01700	SOCIAL SERVICE	49,873	13,195	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	1,434,689	379,590	31,339	89,035	24,203	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,271,587	336,436	29,256	83,120	11,672	50.00
53.00	05300	ANESTHESIOLOGY	45,851	12,131	415	1,178	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	809,185	214,094	5,846	16,608	3,707	54.00
54.01	05401	ULTRASOUND	215,071	56,903	1,691	4,804	3,259	54.01
56.00	05600	RADIOISOTOPE	386,580	102,281	1,357	3,854	888	56.00
57.00	05700	CT SCAN	274,550	72,640	1,705	4,845	3,773	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	289,121	76,496	4,371	12,419	2,423	58.00
60.00	06000	LABORATORY	1,532,959	405,590	8,474	24,075	0	60.00
65.00	06500	RESPIRATORY THERAPY	99,700	26,379	862	2,449	0	65.00
66.00	06600	PHYSICAL THERAPY	860,397	227,644	29,732	84,471	3,318	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	45,294	11,984	820	2,329	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	138,204	36,566	2,690	7,642	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	320,382	84,767	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	127,265	33,672	2,676	7,601	0	75.01
75.02	03952	WOUND CENTER	82,776	21,901	6,995	19,873	0	75.02
76.00	03953	CARDIAC REHAB	126,590	33,493	4,235	12,031	0	76.00
76.01	03030	DIABETES EDUCATION	62,527	16,543	890	2,529	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,528,148	1,727,218	79,731	110,433	1,219	88.00
91.00	09100	EMERGENCY	1,634,086	432,346	14,047	39,907	14,741	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	888,289	235,024	7,730	21,961	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,217,986	5,433,928	296,866	650,906	69,240	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,880	497	942	2,677	0	190.00
194.00	07950	FREESTANDING CLINICS	785,096	207,721	34,664	98,483	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	143,236	37,897	26,331	74,809	5,029	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)	27,148,198	5,680,043	358,803	826,875	74,269	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1349

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

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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						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	538,514					10.00
11.00	01100	814	443,648				11.00
13.00	01300	9,052	335,564	372,077			13.00
15.00	01500	0	0	21,647	220,004		15.00
16.00	01600	2,526	0	22,431	0	1,308,673	16.00
17.00	01700	8,929	0	80,785	0	0	17.00
19.00	01900	0	0	784	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	93,454	108,084	71,843	99,461	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	73,116	0	43,921	47,531	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	11,729	0	14,902	0	0	54.00
54.01	05401	912	0	2,667	0	0	54.01
56.00	05600	2,312	0	1,725	0	0	56.00
57.00	05700	2,982	0	5,490	0	0	57.00
58.00	05800	0	0	1,882	0	0	58.00
60.00	06000	27,822	0	49,098	0	0	60.00
65.00	06500	807	0	12,863	4,451	0	65.00
66.00	06600	14,756	0	314	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	1,308,673	73.00
75.00	03950	0	0	0	0	0	75.00
75.01	03951	1,210	0	0	0	0	75.01
75.02	03952	947	0	0	0	0	75.02
76.00	03953	8,880	0	4,549	0	0	76.00
76.01	03030	667	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	145,447	0	8,314	0	0	88.00
91.00	09100	54,244	0	25,255	68,561	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	4,459	0	627	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		465,065	443,648	369,097	220,004	1,308,673	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	51,076	0	2,980	0	0	194.00
194.01	07951	22,373	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		538,514	443,648	372,077	220,004	1,308,673	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1349

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

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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	17.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	692,522				16.00
17.00	01700	SOCIAL SERVICE	0	63,852			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	49,785	63,852	0	2,445,335	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	53,295	0	0	1,949,934	0
53.00	05300	ANESTHESIOLOGY	0	0	0	59,575	0
54.00	05400	RADIOLOGY - DIAGNOSTIC	31,594	0	0	1,107,665	0
54.01	05401	ULTRASOUND	6,064	0	0	291,371	0
56.00	05600	RADIOISOTOPE	3,510	0	0	502,507	0
57.00	05700	CT SCAN	8,936	0	0	374,921	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,425	0	0	392,137	0
60.00	06000	LABORATORY	41,168	0	0	2,089,186	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	147,511	0
66.00	06600	PHYSICAL THERAPY	20,105	0	0	1,240,737	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	60,427	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	185,102	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	405,149	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,308,673	0
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
75.01	03951	SLEEP LAB	4,787	0	0	177,211	0
75.02	03952	WOUND CENTER	6,064	0	0	138,556	0
76.00	03953	CARDIAC REHAB	319	0	0	190,097	0
76.01	03030	DIABETES EDUCATION	0	0	0	83,156	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	361,262	0	0	8,961,772	0
91.00	09100	EMERGENCY	73,082	0	0	2,356,269	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,158,090	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	665,396	63,852	0	25,625,381	0
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	5,996	0
194.00	07950	FREESTANDING CLINICS	27,126	0	0	1,207,146	0
194.01	07951	THE CENTER - FITNESS CENTER	0	0	0	309,675	0
200.00		Cross Foot Adjustments				0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	692,522	63,852	0	27,148,198	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1349

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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	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	75.00
75.01	03951	SLEEP LAB	75.01
75.02	03952	WOUND CENTER	75.02
76.00	03953	CARDIAC REHAB	76.00
76.01	03030	DIABETES EDUCATION	76.01
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	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
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00
194.00	07950	FREESTANDING CLINICS	194.00
194.01	07951	THE CENTER - FITNESS CENTER	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1349

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

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP		
		0	1.00	1.01		
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	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	111,448	63,809	40,891	261,786	5.00
6.00 00600	MAINTENANCE & REPAIRS	244	31,486	0	498	6.00
7.00 00700	OPERATION OF PLANT	46	53,668	5,583	58,620	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	4,953	0	0	8.00
9.00 00900	HOUSEKEEPING	0	6,730	0	437	9.00
10.00 01000	DIETARY	0	15,489	0	7,149	10.00
11.00 01100	CAFETERIA	0	8,609	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	2,885	0	84	13.00
15.00 01500	PHARMACY	6,018	4,342	0	1,477	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	14,098	10,169	7,669	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	19,983	62,531	0	38,800	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	76,579	58,376	0	88,993	50.00
53.00 05300	ANESTHESIOLOGY	0	827	0	292	53.00
54.00 05400	RADIOLOGY - DIAGNOSTIC	105	11,664	0	125,024	54.00
54.01 05401	ULTRASOUND	0	3,374	0	36,013	54.01
56.00 05600	RADIOISOTOPE	0	2,707	0	0	56.00
57.00 05700	CT SCAN	0	3,402	0	113,004	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	8,722	0	215,215	58.00
60.00 06000	LABORATORY	0	16,909	0	31,350	60.00
65.00 06500	RESPIRATORY THERAPY	9,470	1,720	0	5,354	65.00
66.00 06600	PHYSICAL THERAPY	0	4,521	43,063	11,816	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	1,635	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,367	0	449	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	75.00
75.01 03951	SLEEP LAB	0	5,339	0	1,226	75.01
75.02 03952	WOUND CENTER	0	13,957	0	0	75.02
76.00 03953	CARDIAC REHAB	0	8,450	0	5,127	76.00
76.01 03030	DIABETES EDUCATION	0	1,776	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	15,596	132,338	60,942	104,435	88.00
91.00 09100	EMERGENCY	0	28,027	0	55,038	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	15,424	0	7,011	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	239,489	593,135	160,648	1,176,867	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,880	0	0	190.00
194.00 07950	FREESTANDING CLINICS	98	69,166	0	16,016	194.00
194.01 07951	THE CENTER - FITNESS CENTER	0	0	41,283	11,474	194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	239,587	664,181	201,931	1,204,357	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-1349	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 7/18/2017 10:36 am		
Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT 4.00	ADMINISTRATIVE & GENERAL 5.00	MAINTENANCE & REPAIRS 6.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 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	477,934			5.00
6.00	00600	MAINTENANCE & REPAIRS	0	6,316	38,544		6.00
7.00	00700	OPERATION OF PLANT	0	14,083	2,889	134,889	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,140	267	1,151	7,511
9.00	00900	HOUSEKEEPING	0	9,252	362	1,563	0
10.00	01000	DIETARY	0	7,270	834	3,598	4
11.00	01100	CAFETERIA	0	192	464	2,000	0
13.00	01300	NURSING ADMINISTRATION	0	3,394	155	670	0
15.00	01500	PHARMACY	0	22,452	234	1,009	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,696	1,456	6,281	0
17.00	01700	SOCIAL SERVICE	0	1,110	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	31,939	3,367	14,524	2,446
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	28,308	3,143	13,559	1,180
53.00	05300	ANESTHESIOLOGY	0	1,021	45	192	0
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	18,014	628	2,709	375
54.01	05401	ULTRASOUND	0	4,788	182	784	330
56.00	05600	RADIOISOTOPE	0	8,606	146	629	90
57.00	05700	CT SCAN	0	6,112	183	790	382
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	6,436	470	2,026	245
60.00	06000	LABORATORY	0	34,127	910	3,927	0
65.00	06500	RESPIRATORY THERAPY	0	2,220	93	400	0
66.00	06600	PHYSICAL THERAPY	0	19,154	3,194	13,780	336
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	1,008	88	380	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,077	289	1,247	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	7,132	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
75.01	03951	SLEEP LAB	0	2,833	287	1,240	0
75.02	03952	WOUND CENTER	0	1,843	751	3,242	0
76.00	03953	CARDIAC REHAB	0	2,818	455	1,963	0
76.01	03030	DIABETES EDUCATION	0	1,392	96	413	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	145,339	8,563	18,012	123
91.00	09100	EMERGENCY	0	36,378	1,509	6,510	1,491
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	19,775	830	3,583	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	457,225	31,890	106,182	7,002
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	42	101	437	0
194.00	07950	FREESTANDING CLINICS	0	17,478	3,724	16,066	0
194.01	07951	THE CENTER - FITNESS CENTER	0	3,189	2,829	12,204	509
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	0	477,934	38,544	134,889	7,511

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1349

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

Worksheet B Part II Date/Time Prepared: 7/18/2017 10:36 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						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	18,344					9.00
10.00	01000	28	34,372				10.00
11.00	01100	308	25,998	37,571			11.00
13.00	01300	0	0	2,186	9,374		13.00
15.00	01500	86	0	2,265	0	37,883	15.00
16.00	01600	304	0	8,159	0	0	16.00
17.00	01700	0	0	79	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,183	8,374	7,254	4,238	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,491	0	4,435	2,025	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	400	0	1,505	0	0	54.00
54.01	05401	31	0	269	0	0	54.01
56.00	05600	79	0	174	0	0	56.00
57.00	05700	102	0	554	0	0	57.00
58.00	05800	0	0	190	0	0	58.00
60.00	06000	948	0	4,958	0	0	60.00
65.00	06500	27	0	1,299	190	0	65.00
66.00	06600	503	0	32	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	37,883	73.00
75.00	03950	0	0	0	0	0	75.00
75.01	03951	41	0	0	0	0	75.01
75.02	03952	32	0	0	0	0	75.02
76.00	03953	302	0	459	0	0	76.00
76.01	03030	23	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	4,954	0	839	0	0	88.00
91.00	09100	1,848	0	2,550	2,921	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	152	0	63	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		15,842	34,372	37,270	9,374	37,883	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	1,740	0	301	0	0	194.00
194.01	07951	762	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		18,344	34,372	37,571	9,374	37,883	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-1349		Period: From 07/01/2015 To 06/30/2016		Worksheet B Part II Date/Time Prepared: 7/18/2017 10:36 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	57,832				16.00
17.00	01700	SOCIAL SERVICE	0	1,189			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,158	1,189		201,986	0 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,451	0		283,540	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0		2,377	0 53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,638	0		163,062	0 54.00
54.01	05401	ULTRASOUND	506	0		46,277	0 54.01
56.00	05600	RADIOISOTOPE	293	0		12,724	0 56.00
57.00	05700	CT SCAN	746	0		125,275	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	453	0		233,757	0 58.00
60.00	06000	LABORATORY	3,438	0		96,567	0 60.00
65.00	06500	RESPIRATORY THERAPY	0	0		20,773	0 65.00
66.00	06600	PHYSICAL THERAPY	1,679	0		98,078	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0		0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		3,111	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		10,429	0 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		7,132	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		37,883	0 73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0 75.00
75.01	03951	SLEEP LAB	400	0		11,366	0 75.01
75.02	03952	WOUND CENTER	506	0		20,331	0 75.02
76.00	03953	CARDIAC REHAB	27	0		19,601	0 76.00
76.01	03030	DIABETES EDUCATION	0	0		3,700	0 76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	30,169	0		521,310	0 88.00
91.00	09100	EMERGENCY	6,103	0		142,375	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		46,838	0 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,567	1,189	0	2,108,492	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		2,460	0 190.00
194.00	07950	FREESTANDING CLINICS	2,265	0		126,854	0 194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	0		72,250	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)	57,832	1,189	0	2,310,056	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-1349	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 7/18/2017 10:36 am
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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	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	75.00
75.01	03951	SLEEP LAB	75.01
75.02	03952	WOUND CENTER	75.02
76.00	03953	CARDIAC REHAB	76.00
76.01	03030	DIABETES EDUCATION	76.01
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	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
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00
194.00	07950	FREESTANDING CLINICS	194.00
194.01	07951	THE CENTER - FITNESS CENTER	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1349

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

Worksheet B-1

Date/Time Prepared:
7/18/2017 10:36 am

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
		1.00	1.01	2.00			
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	70,666				1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	0	27,343			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			1,178,062		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	12,781,629	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,789	5,537	256,071	2,708,693	-5,680,043
6.00	00600	MAINTENANCE & REPAIRS	3,350	0	487	195,294	0
7.00	00700	OPERATION OF PLANT	5,710	756	57,340	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	527	0	0	0	0
9.00	00900	HOUSEKEEPING	716	0	427	220,663	0
10.00	01000	DIETARY	1,648	0	6,993	185,338	0
11.00	01100	CAFETERIA	916	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	307	0	82	118,379	0
15.00	01500	PHARMACY	462	0	1,445	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,500	1,377	7,502	285,467	0
17.00	01700	SOCIAL SERVICE	0	0	0	39,952	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,653	0	37,953	979,104	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,211	0	87,050	543,001	0
53.00	05300	ANESTHESIOLOGY	88	0	286	0	0
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,241	0	122,294	386,390	0
54.01	05401	ULTRASOUND	359	0	35,227	96,128	0
56.00	05600	RADIOISOTOPE	288	0	0	4,546	0
57.00	05700	CT SCAN	362	0	110,537	40,674	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	928	0	210,516	22,591	0
60.00	06000	LABORATORY	1,799	0	30,666	482,070	0
65.00	06500	RESPIRATORY THERAPY	183	0	5,237	48,185	0
66.00	06600	PHYSICAL THERAPY	481	5,831	11,558	594,885	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	174	0	0	33,280	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	571	0	439	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
75.01	03951	SLEEP LAB	568	0	1,199	0	0
75.02	03952	WOUND CENTER	1,485	0	0	0	0
76.00	03953	CARDIAC REHAB	899	0	5,015	86,877	0
76.01	03030	DIABETES EDUCATION	189	0	0	44,905	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	14,080	8,252	102,155	3,870,530	0
91.00	09100	EMERGENCY	2,982	0	53,836	675,280	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,641	0	6,858	578,816	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	63,107	21,753	1,151,173	12,241,048	-5,680,043
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	200	0	0	0	0
194.00	07950	FREESTANDING CLINICS	7,359	0	15,666	472,761	0
194.01	07951	THE CENTER - FITNESS CENTER	0	5,590	11,223	67,820	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	664,181	201,931	1,204,357	2,927,943	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.398876	7.385108	1.022321	0.229074	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 07/01/2015
To 06/30/2016

Worksheet B-1

Date/Time Prepared:
7/18/2017 10:36 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	21,468,155				5.00
6.00	00600	MAINTENANCE & REPAIRS	283,733	76,172			6.00
7.00	00700	OPERATION OF PLANT	632,604	5,710	61,787		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	51,190	527	527	10,117	8.00
9.00	00900	HOUSEKEEPING	415,600	716	716	0	153,491
10.00	01000	DIETARY	326,574	1,648	1,648	5	232
11.00	01100	CAFETERIA	8,609	916	916	0	2,580
13.00	01300	NURSING ADMINISTRATION	152,464	307	307	0	0
15.00	01500	PHARMACY	1,008,522	462	462	0	720
16.00	01600	MEDICAL RECORDS & LIBRARY	435,523	2,877	2,877	0	2,545
17.00	01700	SOCIAL SERVICE	49,873	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,434,689	6,653	6,653	3,297	26,637
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,271,587	6,211	6,211	1,590	20,840
53.00	05300	ANESTHESIOLOGY	45,851	88	88	0	0
54.00	05400	RADIOLOGY - DIAGNOSTIC	809,185	1,241	1,241	505	3,343
54.01	05401	ULTRASOUND	215,071	359	359	444	260
56.00	05600	RADIOISOTOPE	386,580	288	288	121	659
57.00	05700	CT SCAN	274,550	362	362	514	850
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	289,121	928	928	330	0
60.00	06000	LABORATORY	1,532,959	1,799	1,799	0	7,930
65.00	06500	RESPIRATORY THERAPY	99,700	183	183	0	230
66.00	06600	PHYSICAL THERAPY	860,397	6,312	6,312	452	4,206
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	45,294	174	174	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	138,204	571	571	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	320,382	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
75.01	03951	SLEEP LAB	127,265	568	568	0	345
75.02	03952	WOUND CENTER	82,776	1,485	1,485	0	270
76.00	03953	CARDIAC REHAB	126,590	899	899	0	2,531
76.01	03030	DIABETES EDUCATION	62,527	189	189	0	190
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	6,528,148	16,927	8,252	166	41,456
91.00	09100	EMERGENCY	1,634,086	2,982	2,982	2,008	15,461
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	888,289	1,641	1,641	0	1,271
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,537,943	63,023	48,638	9,432	132,556
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,880	200	200	0	0
194.00	07950	FREESTANDING CLINICS	785,096	7,359	7,359	0	14,558
194.01	07951	THE CENTER - FITNESS CENTER	143,236	5,590	5,590	685	6,377
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	5,680,043	358,803	826,875	74,269	538,514
203.00		Unit cost multiplier (Wkst. B, Part I)	0.264580	4.710432	13.382669	7.341010	3.508440
204.00		Cost to be allocated (per Wkst. B, Part II)	477,934	38,544	134,889	7,511	18,344
205.00		Unit cost multiplier (Wkst. B, Part II)	0.022262	0.506013	2.183129	0.742414	0.119512

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1349

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

Worksheet B-1

Date/Time Prepared:
7/18/2017 10:36 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						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	25,375					10.00
11.00	01100	19,193	2,372				11.00
13.00	01300	0	138	94,415			13.00
15.00	01500	0	143	0	1,594,442		15.00
16.00	01600	0	515	0	0	2,170	16.00
17.00	01700	0	5	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,182	458	42,684	0	156	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	280	20,398	0	167	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	95	0	0	99	54.00
54.01	05401	0	17	0	0	19	54.01
56.00	05600	0	11	0	0	11	56.00
57.00	05700	0	35	0	0	28	57.00
58.00	05800	0	12	0	0	17	58.00
60.00	06000	0	313	0	0	129	60.00
65.00	06500	0	82	1,910	0	0	65.00
66.00	06600	0	2	0	0	63	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	1,594,442	0	73.00
75.00	03950	0	0	0	0	0	75.00
75.01	03951	0	0	0	0	15	75.01
75.02	03952	0	0	0	0	19	75.02
76.00	03953	0	29	0	0	1	76.00
76.01	03030	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	53	0	0	1,132	88.00
91.00	09100	0	161	29,423	0	229	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	4	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		25,375	2,353	94,415	1,594,442	2,085	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	19	0	0	85	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		443,648	372,077	220,004	1,308,673	692,522	202.00
203.00		17,483,665	156,862,142	2,330,181	0,820,772	319,134,562	203.00
204.00		34,372	37,571	9,374	37,883	57,832	204.00
205.00		1,354,562	15,839,376	0,099,285	0,023,759	26,650,691	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1349

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

Worksheet B-1

Date/Time Prepared:
7/18/2017 10:36 am

Cost Center Description		SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		17.00	19.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
1.01	00101			1.01
2.00	00200			2.00
4.00	00400			4.00
5.00	00500			5.00
6.00	00600			6.00
7.00	00700			7.00
8.00	00800			8.00
9.00	00900			9.00
10.00	01000			10.00
11.00	01100			11.00
13.00	01300			13.00
15.00	01500			15.00
16.00	01600			16.00
17.00	01700	956		17.00
19.00	01900	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	956	0	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	0	0	50.00
53.00	05300	0	0	53.00
54.00	05400	0	0	54.00
54.01	05401	0	0	54.01
56.00	05600	0	0	56.00
57.00	05700	0	0	57.00
58.00	05800	0	0	58.00
60.00	06000	0	0	60.00
65.00	06500	0	0	65.00
66.00	06600	0	0	66.00
67.00	06700	0	0	67.00
68.00	06800	0	0	68.00
69.00	06900	0	0	69.00
71.00	07100	0	0	71.00
72.00	07200	0	0	72.00
73.00	07300	0	0	73.00
75.00	03950	0	0	75.00
75.01	03951	0	0	75.01
75.02	03952	0	0	75.02
76.00	03953	0	0	76.00
76.01	03030	0	0	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	0	0	88.00
91.00	09100	0	0	91.00
92.00	09200	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300			113.00
118.00		956	0	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	0	0	190.00
194.00	07950	0	0	194.00
194.01	07951	0	0	194.01
200.00				200.00
201.00				201.00
202.00		63,852	0	202.00
203.00		66.790795	0.000000	203.00
204.00		1,189	0	204.00
205.00		1.243724	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1349

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

Worksheet C
Part I
Date/Time Prepared:
7/18/2017 10:36 am

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2,445,335		2,445,335	0	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,949,934		1,949,934	0	0 50.00
53.00	05300 ANESTHESIOLOGY	59,575		59,575	0	0 53.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	1,107,665		1,107,665	0	0 54.00
54.01	05401 ULTRASOUND	291,371		291,371	0	0 54.01
56.00	05600 RADIOISOTOPE	502,507		502,507	0	0 56.00
57.00	05700 CT SCAN	374,921		374,921	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	392,137		392,137	0	0 58.00
60.00	06000 LABORATORY	2,089,186		2,089,186	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	147,511	0	147,511	0	0 65.00
66.00	06600 PHYSICAL THERAPY	1,240,737	0	1,240,737	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	60,427		60,427	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	185,102		185,102	0	0 71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	405,149		405,149	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,308,673		1,308,673	0	0 73.00
75.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0 75.00
75.01	03951 SLEEP LAB	177,211		177,211	0	0 75.01
75.02	03952 WOUND CENTER	138,556		138,556	0	0 75.02
76.00	03953 CARDIAC REHAB	190,097		190,097	0	0 76.00
76.01	03030 DIABETES EDUCATION	83,156		83,156	0	0 76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	8,961,772		8,961,772	0	0 88.00
91.00	09100 EMERGENCY	2,356,269		2,356,269	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	648,951		648,951	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1,158,090		1,158,090		0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	26,274,332	0	26,274,332	0	0 200.00
201.00	Less Observation Beds	648,951		648,951		0 201.00
202.00	Total (see instructions)	25,625,381	0	25,625,381	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1349

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

Worksheet C
Part I
Date/Time Prepared:
7/18/2017 10:36 am

		Title XVIII			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	813,928		813,928			30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	298,724	4,507,996	4,806,720	0.405668	0.000000	50.00
53.00	05300 ANESTHESIOLOGY	19,647	125,028	144,675	0.411785	0.000000	53.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	43,323	2,784,164	2,827,487	0.391749	0.000000	54.00
54.01	05401 ULTRASOUND	152,368	3,177,597	3,329,965	0.087500	0.000000	54.01
56.00	05600 RADIOISOTOPE	26,871	1,699,845	1,726,716	0.291019	0.000000	56.00
57.00	05700 CT SCAN	143,596	9,866,938	10,010,534	0.037453	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	19,404	2,706,383	2,725,787	0.143862	0.000000	58.00
60.00	06000 LABORATORY	370,006	9,931,979	10,301,985	0.202795	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	68,315	273,121	341,436	0.432031	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	454,866	4,417,053	4,871,919	0.254671	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	13,650	448,316	461,966	0.130804	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	149,826	919,586	1,069,412	0.173088	0.000000	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	244,462	398,856	643,318	0.629780	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	328,174	1,971,334	2,299,508	0.569110	0.000000	73.00
75.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	75.00
75.01	03951 SLEEP LAB	0	676,252	676,252	0.262049	0.000000	75.01
75.02	03952 WOUND CENTER	0	275,755	275,755	0.502461	0.000000	75.02
76.00	03953 CARDIAC REHAB	0	201,454	201,454	0.943625	0.000000	76.00
76.01	03030 DIABETES EDUCATION	0	25,192	25,192	3.300889	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	6,594,538	6,594,538			88.00
91.00	09100 EMERGENCY	51,175	6,620,438	6,671,613	0.353178	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5,050	348,253	353,303	1.836811	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	0	1,774,214	1,774,214			101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	3,203,385	59,744,292	62,947,677			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	3,203,385	59,744,292	62,947,677			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1349

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

Worksheet C
Part I
Date/Time Prepared:
7/18/2017 10:36 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		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 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Prepared: 7/18/2017 10:36 am
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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	283,540	4,806,720	0.058988	171,326	10,106	50.00
53.00	05300 ANESTHESIOLOGY	2,377	144,675	0.016430	10,129	166	53.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	163,062	2,827,487	0.057670	23,727	1,368	54.00
54.01	05401 ULTRASOUND	46,277	3,329,965	0.013897	98,126	1,364	54.01
56.00	05600 RADIOISOTOPE	12,724	1,726,716	0.007369	13,571	100	56.00
57.00	05700 CT SCAN	125,275	10,010,534	0.012514	77,899	975	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	233,757	2,725,787	0.085758	9,582	822	58.00
60.00	06000 LABORATORY	96,567	10,301,985	0.009374	234,156	2,195	60.00
65.00	06500 RESPIRATORY THERAPY	20,773	341,436	0.060840	32,437	1,973	65.00
66.00	06600 PHYSICAL THERAPY	98,078	4,871,919	0.020131	96,607	1,945	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	3,111	461,966	0.006734	8,400	57	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10,429	1,069,412	0.009752	80,064	781	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	7,132	643,318	0.011086	175,774	1,949	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	37,883	2,299,508	0.016474	150,230	2,475	73.00
75.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	75.00
75.01	03951 SLEEP LAB	11,366	676,252	0.016807	0	0	75.01
75.02	03952 WOUND CENTER	20,331	275,755	0.073728	0	0	75.02
76.00	03953 CARDIAC REHAB	19,601	201,454	0.097298	0	0	76.00
76.01	03030 DIABETES EDUCATION	3,700	25,192	0.146872	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	521,310	6,594,538	0.079052	0	0	88.00
91.00	09100 EMERGENCY	142,375	6,671,613	0.021340	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	53,604	353,303	0.151722	601	91	92.00
200.00	Total (lines 50-199)	1,913,272	60,359,535		1,182,629	26,367	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1349

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

Worksheet D
Part IV
Date/Time Prepared:
7/18/2017 10:36 am

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1349	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 7/18/2017 10:36 am
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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	Cost
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	4,806,720	0.000000	0.000000	171,326	50.00
53.00	05300 ANESTHESIOLOGY	0	144,675	0.000000	0.000000	10,129	53.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	2,827,487	0.000000	0.000000	23,727	54.00
54.01	05401 ULTRASOUND	0	3,329,965	0.000000	0.000000	98,126	54.01
56.00	05600 RADIOISOTOPE	0	1,726,716	0.000000	0.000000	13,571	56.00
57.00	05700 CT SCAN	0	10,010,534	0.000000	0.000000	77,899	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2,725,787	0.000000	0.000000	9,582	58.00
60.00	06000 LABORATORY	0	10,301,985	0.000000	0.000000	234,156	60.00
65.00	06500 RESPIRATORY THERAPY	0	341,436	0.000000	0.000000	32,437	65.00
66.00	06600 PHYSICAL THERAPY	0	4,871,919	0.000000	0.000000	96,607	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	461,966	0.000000	0.000000	8,400	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,069,412	0.000000	0.000000	80,064	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	643,318	0.000000	0.000000	175,774	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,299,508	0.000000	0.000000	150,230	73.00
75.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	75.00
75.01	03951 SLEEP LAB	0	676,252	0.000000	0.000000	0	75.01
75.02	03952 WOUND CENTER	0	275,755	0.000000	0.000000	0	75.02
76.00	03953 CARDIAC REHAB	0	201,454	0.000000	0.000000	0	76.00
76.01	03030 DIABETES EDUCATION	0	25,192	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	6,594,538	0.000000	0.000000	0	88.00
91.00	09100 EMERGENCY	0	6,671,613	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	353,303	0.000000	0.000000	601	92.00
200.00	Total (lines 50-199)	0	60,359,535			1,182,629	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1349	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 7/18/2017 10:36 am
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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)	Cost
		11.00	12.00	13.00	
Title XVIII Hospital Cost					
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 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 7/18/2017 10:36 am
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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	0.405668	0	1,656,681	0	0
53.00	05300 ANESTHESIOLOGY	0.411785	0	28,556	0	0
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.391749	0	1,032,061	0	0
54.01	05401 ULTRASOUND	0.087500	0	1,178,897	0	0
56.00	05600 RADIOISOTOPE	0.291019	0	774,744	0	0
57.00	05700 CT SCAN	0.037453	0	3,511,512	0	0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.143862	0	853,434	0	0
60.00	06000 LABORATORY	0.202795	0	3,763,963	0	0
65.00	06500 RESPIRATORY THERAPY	0.432031	0	120,177	0	0
66.00	06600 PHYSICAL THERAPY	0.254671	0	1,636,250	0	0
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0
69.00	06900 ELECTROCARDIOLOGY	0.130804	0	192,819	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173088	0	285,368	0	0
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.629780	0	102,834	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.569110	0	1,579,897	326	0
75.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0
75.01	03951 SLEEP LAB	0.262049	0	198,061	0	0
75.02	03952 WOUND CENTER	0.502461	0	125,845	0	0
76.00	03953 CARDIAC REHAB	0.943625	0	116,108	0	0
76.01	03030 DIABETES EDUCATION	3.300889	0	9,193	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0
91.00	09100 EMERGENCY	0.353178	0	1,395,611	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.836811	0	172,079	0	0
200.00	Subtotal (see instructions)		0	18,734,090	326	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	18,734,090	326	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1349	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 7/18/2017 10:36 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	672,062	0		50.00
53.00 05300 ANESTHESIOLOGY	11,759	0		53.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	404,309	0		54.00
54.01 05401 ULTRASOUND	103,153	0		54.01
56.00 05600 RADIOISOTOPE	225,465	0		56.00
57.00 05700 CT SCAN	131,517	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	122,777	0		58.00
60.00 06000 LABORATORY	763,313	0		60.00
65.00 06500 RESPIRATORY THERAPY	51,920	0		65.00
66.00 06600 PHYSICAL THERAPY	416,705	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	25,221	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	49,394	0		71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	64,763	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	899,135	186		73.00
75.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		75.00
75.01 03951 SLEEP LAB	51,902	0		75.01
75.02 03952 WOUND CENTER	63,232	0		75.02
76.00 03953 CARDIAC REHAB	109,562	0		76.00
76.01 03030 DIABETES EDUCATION	30,345	0		76.01
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
91.00 09100 EMERGENCY	492,899	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	316,077	0		92.00
200.00 Subtotal (see instructions)	5,005,510	186		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	5,005,510	186		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1349

Period: From 07/01/2015

Worksheet D

Component CCN: 14-Z349

To 06/30/2016

Part V
Date/Time Prepared:
7/18/2017 10:36 am

Title XVIII

Swing Beds - SNF

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.)
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.405668	0	0	0	0 50.00
53.00 05300 ANESTHESIOLOGY	0.411785	0	0	0	0 53.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0.391749	0	0	0	0 54.00
54.01 05401 ULTRASOUND	0.087500	0	0	0	0 54.01
56.00 05600 RADIOISOTOPE	0.291019	0	0	0	0 56.00
57.00 05700 CT SCAN	0.037453	0	0	0	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.143862	0	0	0	0 58.00
60.00 06000 LABORATORY	0.202795	0	0	0	0 60.00
65.00 06500 RESPIRATORY THERAPY	0.432031	0	0	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0.254671	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	0.130804	0	0	0	0 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173088	0	0	0	0 71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.629780	0	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.569110	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	0.262049	0	0	0	0 75.01
75.02 03952 WOUND CENTER	0.502461	0	0	0	0 75.02
76.00 03953 CARDIAC REHAB	0.943625	0	0	0	0 76.00
76.01 03030 DIABETES EDUCATION	3.300889	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	0.353178	0	0	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.836811	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	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 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 7/18/2017 10:36 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost	
	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	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 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 7/18/2017 10:36 am
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,264	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,509	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)		956	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		274	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		275	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		103	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		103	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		626	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		274	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		275	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		143.61	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		150.15	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,445,335	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		14,792	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		15,465	25.00
26.00	Total swing-bed cost (see instructions)		674,514	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,770,821	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)		1,770,821	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)		1,173.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		734,617	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)		734,617	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1349		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1	
		Title XVIII		Hospital		Date/Time Prepared: 7/18/2017 10:36 am	
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)					398,158	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,132,775	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)					321,542	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					322,715	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					644,257	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					553	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,173.51	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					648,951	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1349		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 7/18/2017 10:36 am	
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	201,986	2,445,335	0.082601	648,951	53,604	90.00
91.00	Nursing School cost	0	2,445,335	0.000000	648,951	0	91.00
92.00	Allied health cost	0	2,445,335	0.000000	648,951	0	92.00
93.00	All other Medical Education	0	2,445,335	0.000000	648,951	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1349	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 7/18/2017 10:36 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		313,000		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.405668	171,326	69,501	50.00
53.00	05300 ANESTHESIOLOGY	0.411785	10,129	4,171	53.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.391749	23,727	9,295	54.00
54.01	05401 ULTRASOUND	0.087500	98,126	8,586	54.01
56.00	05600 RADIOISOTOPE	0.291019	13,571	3,949	56.00
57.00	05700 CT SCAN	0.037453	77,899	2,918	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.143862	9,582	1,378	58.00
60.00	06000 LABORATORY	0.202795	234,156	47,486	60.00
65.00	06500 RESPIRATORY THERAPY	0.432031	32,437	14,014	65.00
66.00	06600 PHYSICAL THERAPY	0.254671	96,607	24,603	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	0.130804	8,400	1,099	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173088	80,064	13,858	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.629780	175,774	110,699	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.569110	150,230	85,497	73.00
75.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	75.00
75.01	03951 SLEEP LAB	0.262049	0	0	75.01
75.02	03952 WOUND CENTER	0.502461	0	0	75.02
76.00	03953 CARDIAC REHAB	0.943625	0	0	76.00
76.01	03030 DIABETES EDUCATION	3.300889	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.353178	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.836811	601	1,104	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,182,629	398,158	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		1,182,629		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1349 Component CCN: 14-Z349	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 7/18/2017 10:36 am	
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	0.405668	964	391	50.00
53.00	05300 ANESTHESIOLOGY	0.411785	0	0	53.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.391749	3,584	1,404	54.00
54.01	05401 ULTRASOUND	0.087500	9,196	805	54.01
56.00	05600 RADIOISOTOPE	0.291019	0	0	56.00
57.00	05700 CT SCAN	0.037453	7,253	272	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.143862	0	0	58.00
60.00	06000 LABORATORY	0.202795	36,933	7,490	60.00
65.00	06500 RESPIRATORY THERAPY	0.432031	15,217	6,574	65.00
66.00	06600 PHYSICAL THERAPY	0.254671	233,053	59,352	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	0.130804	788	103	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173088	8,440	1,461	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.629780	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.569110	80,159	45,619	73.00
75.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	75.00
75.01	03951 SLEEP LAB	0.262049	0	0	75.01
75.02	03952 WOUND CENTER	0.502461	0	0	75.02
76.00	03953 CARDIAC REHAB	0.943625	0	0	76.00
76.01	03030 DIABETES EDUCATION	3.300889	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.353178	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.836811	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		395,587	123,471	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		395,587		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1349	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 7/18/2017 10:36 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,005,696 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)			5,005,696 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 charge basis 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)			5,055,753 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			35,727 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,982,134 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			2,037,892 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,037,892 30.00
31.00	Primary payer payments			1,156 31.00
32.00	Subtotal (line 30 minus line 31)			2,036,736 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			365,678 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			237,691 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			237,218 36.00
37.00	Subtotal (see instructions)			2,274,427 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)			2,274,427 40.00
40.01	Sequestration adjustment (see instructions)			45,489 40.01
41.00	Interim payments			2,506,110 41.00
42.00	Tentative settlement (for contractors use only)			-192,646 42.00
43.00	Balance due provider/program (see instructions)			-84,526 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 07/01/2015
To 06/30/2016

Worksheet E-1
Part I
Date/Time Prepared:
7/18/2017 10:36 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		908,244		2,702,457	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	01/28/2016	34,191		0	3.01	
3.02		06/16/2016	36,471		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0	01/28/2016	156,361	3.50	
3.51			0	06/16/2016	39,986	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		70,662		-196,347	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		978,906		2,506,110	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER	02/02/2017	7,733		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0	02/02/2017	192,646	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)		7,733		-192,646	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		32,530		84,526	6.02	
7.00	Total Medicare program liability (see instructions)		954,109		2,228,938	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 07/01/2015
To 06/30/2016

Worksheet E-1
Part I
Date/Time Prepared:
7/18/2017 10:36 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		677,310		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	01/28/2016	39,234		0	3.01
3.02		06/16/2016	30,975		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		70,209		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		747,519		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER	02/02/2017	32,742		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)		32,742		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		29,210		0	6.02
7.00	Total Medicare program liability (see instructions)		751,051		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 07/01/2015
To 06/30/2016

Worksheet E-1
Part II
Date/Time Prepared:
7/18/2017 10:36 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			344 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			626 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			28 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			956 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			62,947,677 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			63,830 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			0 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			0 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1349	Period: From 07/01/2015	Worksheet E-2
Component CCN: 14-Z349	To 06/30/2016	Date/Time Prepared: 7/18/2017 10:36 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)	650,700	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)	124,706	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	549	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	775,406	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	775,406	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)	775,406	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	9,027	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	766,379	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)	766,379	0	19.00
19.01	Sequestration adjustment (see instructions)	15,328	0	19.01
20.00	Interim payments	747,519	0	20.00
21.00	Tentative settlement (for contractor use only)	32,742	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-29,210	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 07/01/2015 To 06/30/2016	Worksheet E-3 Part V Date/Time Prepared: 7/18/2017 10:36 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			1,132,775 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)			1,132,775 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,144,103 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)			1,144,103 19.00
20.00	Deductibles (exclude professional component)			196,243 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			947,860 22.00
23.00	Coinsurance			8,974 23.00
24.00	Subtotal (line 22 minus line 23)			938,886 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			53,377 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			34,695 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			34,625 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			973,581 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)			973,581 30.00
30.01	Sequestration adjustment (see instructions)			19,472 30.01
31.00	Interim payments			978,906 31.00
32.00	Tentative settlement (for contractor use only)			7,733 32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)			-32,530 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 07/01/2015
To 06/30/2016

Worksheet G

Date/Time Prepared:
7/18/2017 10:36 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	7,644,739	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	16,665,498	0	0	0	4.00
5.00	Other receivable	207,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,781,298	0	0	0	6.00
7.00	Inventory	568,893	0	0	0	7.00
8.00	Prepaid expenses	840,310	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	48,213	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	15,193,355	0	0	0	11.00
FIXED ASSETS						
12.00	Land	236,334	0	0	0	12.00
13.00	Land improvements	845,711	0	0	0	13.00
14.00	Accumulated depreciation	-640,335	0	0	0	14.00
15.00	Buildings	16,710,703	0	0	0	15.00
16.00	Accumulated depreciation	-12,005,113	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	23,015	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	14,128,110	0	0	0	23.00
24.00	Accumulated depreciation	-9,930,126	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	74,835	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	9,443,134	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	2,289,419	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,289,419	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	26,925,908	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	567,721	0	0	0	37.00
38.00	Salaries, wages, and fees payable	878,313	0	0	0	38.00
39.00	Payroll taxes payable	872,699	0	0	0	39.00
40.00	Notes and loans payable (short term)	455,817	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,774,550	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,834,441	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,834,441	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,608,991	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	21,316,917	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	21,316,917	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	26,925,908	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1349

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

Worksheet G-1

Date/Time Prepared:
7/18/2017 10:36 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		20,454,816		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		862,101			2.00
3.00	Total (sum of line 1 and line 2)		21,316,917		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		21,316,917		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		21,316,917		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1349

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
7/18/2017 10:36 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	624,000		624,000	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	116,060		116,060	5.00
6.00	Swing bed - NF	21,420		21,420	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	761,480		761,480	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	761,480		761,480	17.00
18.00	Ancillary services	2,334,541	45,070,434	47,404,975	18.00
19.00	Outpatient services	-44,210	7,184,260	7,140,050	19.00
20.00	RURAL HEALTH CLINIC	0	6,766,943	6,766,943	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,774,214	1,774,214	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	37,483	677,748	715,231	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,089,294	61,473,599	64,562,893	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		30,550,849		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		30,550,849		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1349

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

Worksheet G-3

Date/Time Prepared:
7/18/2017 10:36 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	64,562,893	1.00
2.00	Less contractual allowances and discounts on patients' accounts	35,730,348	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,832,545	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	30,550,849	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,718,304	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	266,251	6.00
7.00	Income from investments	58,843	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	41,373	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	2,917	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	149,744	22.00
23.00	Governmental appropriations	249,241	23.00
24.00	OTHER MISC REVENUES	575,246	24.00
24.01	340B CONTRACT PHARMACY REVENUE	1,236,790	24.01
25.00	Total other income (sum of lines 6-24)	2,580,405	25.00
26.00	Total (line 5 plus line 25)	862,101	26.00
27.00	GAIN AND LOSS ON IMPAIRMENT	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	862,101	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1349

Period: From 07/01/2015

Worksheet H

HHA CCN: 14-7694

To 06/30/2016

Date/Time Prepared: 7/18/2017 10:36 am

Home Health Agency I

PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	19,511	19,511	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	250,948	0	0	0	122,709	373,657	5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	212,161	0	0	0	0	212,161	6.00
7.00	Physical Therapy	115,343	0	0	270	0	115,613	7.00
8.00	Occupational Therapy	0	0	0	15,454	0	15,454	8.00
9.00	Speech Pathology	0	0	0	5,584	0	5,584	9.00
10.00	Medical Social Services	0	0	0	60	0	60	10.00
11.00	Home Health Aide	364	0	0	0	0	364	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	578,816	0	0	21,368	142,220	742,404	24.00
		Reclassified	Reclassified	Adjustments	Net Expenses			
		7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	19,511	-9,142	10,369			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	373,657	0	373,657			5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	212,161	0	212,161			6.00
7.00	Physical Therapy	0	115,613	0	115,613			7.00
8.00	Occupational Therapy	0	15,454	0	15,454			8.00
9.00	Speech Pathology	0	5,584	0	5,584			9.00
10.00	Medical Social Services	0	60	0	60			10.00
11.00	Home Health Aide	0	364	0	364			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	742,404	-9,142	733,262			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	Period: From 07/01/2015	Worksheet H-1
		HHA CCN: 14-7694	To 06/30/2016	Part I
				Date/Time Prepared: 7/18/2017 10:36 am
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	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
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	10,369	0	0	10,369	0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	373,657	0	0	10,369	0	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	212,161	0	0	0	0	6.00	
7.00	Physical Therapy	115,613	0	0	0	0	7.00	
8.00	Occupational Therapy	15,454	0	0	0	0	8.00	
9.00	Speech Pathology	5,584	0	0	0	0	9.00	
10.00	Medical Social Services	60	0	0	0	0	10.00	
11.00	Home Health Aide	364	0	0	0	0	11.00	
12.00	Supplies (see instructions)	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	14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	733,262	0	0	10,369	0	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	384,026					5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	233,297	445,458				6.00	
7.00	Physical Therapy	127,130	242,743				7.00	
8.00	Occupational Therapy	16,993	32,447				8.00	
9.00	Speech Pathology	6,140	11,724				9.00	
10.00	Medical Social Services	66	126				10.00	
11.00	Home Health Aide	400	764				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)		733,262				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-1349
HHA CCN: 14-7694

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

Worksheet H-1
Part II
Date/Time Prepared:
7/18/2017 10:36 am

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
1.00	2.00	3.00	4.00					
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	-384,026	349,236	5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	0	0	0	0	212,161	6.00
7.00	Physical Therapy	0	0	0	0	0	115,613	7.00
8.00	Occupational Therapy	0	0	0	0	0	15,454	8.00
9.00	Speech Pathology	0	0	0	0	0	5,584	9.00
10.00	Medical Social Services	0	0	0	0	0	60	10.00
11.00	Home Health Aide	0	0	0	0	0	364	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	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	-384,026	349,236	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	10,369	0		384,026	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	6.318708	0.000000		1.099617	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1349

Period: From 07/01/2015

Worksheet H-2

HHA CCN: 14-7694

To 06/30/2016

Part I
Date/Time Prepared:
7/18/2017 10:36 am

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP				
		1.00	1.01	2.00	4.00			
	0	15,424	0	7,011	57,486	79,921	1.00	
1.00 Administrative and General	0	15,424	0	7,011	57,486	79,921	1.00	
2.00 Skilled Nursing Care	445,458	0	0	0	48,601	494,059	2.00	
3.00 Physical Therapy	242,743	0	0	0	26,422	269,165	3.00	
4.00 Occupational Therapy	32,447	0	0	0	0	32,447	4.00	
5.00 Speech Pathology	11,724	0	0	0	0	11,724	5.00	
6.00 Medical Social Services	126	0	0	0	0	126	6.00	
7.00 Home Health Aide	764	0	0	0	83	847	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)	733,262	15,424	0	7,011	132,592	888,289	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.000000	21.00	
Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
	5.00	6.00	7.00	8.00	9.00	10.00		
1.00 Administrative and General	21,146	7,730	21,961	0	4,459	0	1.00	
2.00 Skilled Nursing Care	130,718	0	0	0	0	0	2.00	
3.00 Physical Therapy	71,216	0	0	0	0	0	3.00	
4.00 Occupational Therapy	8,585	0	0	0	0	0	4.00	
5.00 Speech Pathology	3,102	0	0	0	0	0	5.00	
6.00 Medical Social Services	33	0	0	0	0	0	6.00	
7.00 Home Health Aide	224	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)	235,024	7,730	21,961	0	4,459	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 07/01/2015

Worksheet H-2

HHA CCN: 14-7694

To 06/30/2016

Part I
Date/Time Prepared:
7/18/2017 10:36 am

Home Health Agency I

PPS

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	627	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)	627	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	135,844	0	135,844				1.00
2.00	Skilled Nursing Care	624,777	0	624,777	83,025	707,802		2.00
3.00	Physical Therapy	340,381	0	340,381	45,233	385,614		3.00
4.00	Occupational Therapy	41,032	0	41,032	5,453	46,485		4.00
5.00	Speech Pathology	14,826	0	14,826	1,970	16,796		5.00
6.00	Medical Social Services	159	0	159	21	180		6.00
7.00	Home Health Aide	1,071	0	1,071	142	1,213		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)	1,158,090	0	1,158,090	135,844	1,158,090		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.				0.132888			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 07/01/2015 To 06/30/2016	Worksheet H-2 Part II Date/Time Prepared: 7/18/2017 10:36 am
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		Home Health Agency I	PPS
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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	1.01	2.00				
1.00 Administrative and General	1,641	0	6,858	250,948	0	79,921	1.00
2.00 Skilled Nursing Care	0	0	0	212,161	0	494,059	2.00
3.00 Physical Therapy	0	0	0	115,343	0	269,165	3.00
4.00 Occupational Therapy	0	0	0	0	0	32,447	4.00
5.00 Speech Pathology	0	0	0	0	0	11,724	5.00
6.00 Medical Social Services	0	0	0	0	0	126	6.00
7.00 Home Health Aide	0	0	0	364	0	847	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	6,858	578,816	0	888,289	20.00
21.00 Total cost to be allocated	15,424	0	7,011	132,592	0	235,024	21.00
22.00 Unit cost multiplier	9.399147	0.000000	1.022310	0.229075	0	0.264581	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	1,271	0	4	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	1,641	1,641	0	1,271	0	4	20.00
21.00 Total cost to be allocated	7,730	21,961	0	4,459	0	627	21.00
22.00 Unit cost multiplier	4.710542	13.382693	0.000000	3.508261	0.000000	156.750000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1349

HHA CCN: 14-7694

Period:

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

Worksheet H-2

Part II
Date/Time Prepared:
7/18/2017 10:36 am

Home Health Agency I

PPS

Cost Center Description	NURSING ADMINISTRATION	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)							
	(DIRECT NURS. HRS.)					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	Period: 07/01/2015	Worksheet H-3
		HHA CCN: 14-7694	To 06/30/2016	Part I
		Title XVIII		Date/Time Prepared: 7/18/2017 10:36 am
		Home Health Agency I		PPS

Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	707,802		707,802	4,102	172.55	1.00
2.00	Physical Therapy	3.00	385,614	0	385,614	3,474	111.00	2.00
3.00	Occupational Therapy	4.00	46,485	0	46,485	117	397.31	3.00
4.00	Speech Pathology	5.00	16,796	0	16,796	91	184.57	4.00
5.00	Medical Social Services	6.00	180		180	1	180.00	5.00
6.00	Home Health Aide	7.00	1,213		1,213	11	110.27	6.00
7.00	Total (sum of lines 1-6)		1,158,090	0	1,158,090	7,796		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits		5.00
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	

Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	1,689		8.00
8.01	Skilled Nursing Care		41180	0	156		8.01
8.02	Skilled Nursing Care		16060	0	70		8.02
9.00	Physical Therapy		99914	0	1,724		9.00
9.01	Physical Therapy		41180	0	193		9.01
9.02	Physical Therapy		16060	0	100		9.02
10.00	Occupational Therapy		99914	0	49		10.00
10.01	Occupational Therapy		41180	0	17		10.01
10.02	Occupational Therapy		16060	0	0		10.02
11.00	Speech Pathology		99914	0	26		11.00
11.01	Speech Pathology		41180	0	1		11.01
11.02	Speech Pathology		16060	0	0		11.02
12.00	Medical Social Services		99914	0	1		12.00
12.01	Medical Social Services		41180	0	0		12.01
12.02	Medical Social Services		16060	0	0		12.02
13.00	Home Health Aide		99914	0	8		13.00
13.01	Home Health Aide		41180	0	0		13.01
13.02	Home Health Aide		16060	0	0		13.02
14.00	Total (sum of lines 8-13)			0	4,034		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	3,198	3,198	18,475	0.173099	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

Cost Center Description	Part A	Part B		Part A	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
	6.00	7.00	8.00	9.00	10.00	11.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,915		0	330,433	1.00
2.00	Physical Therapy	0	2,017		0	223,887	2.00
3.00	Occupational Therapy	0	66		0	26,222	3.00
4.00	Speech Pathology	0	27		0	4,983	4.00
5.00	Medical Social Services	0	1		0	180	5.00
6.00	Home Health Aide	0	8		0	882	6.00
7.00	Total (sum of lines 1-6)	0	4,034		0	586,587	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1349

Period: From 07/01/2015

Worksheet H-3

HHA CCN: 14-7694

To 06/30/2016

Part I
Date/Time Prepared:
7/18/2017 10:36 am

Title XVIII

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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 A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of col.s. 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	330,433						1.00
2.00	Physical Therapy	223,887						2.00
3.00	Occupational Therapy	26,222						3.00
4.00	Speech Pathology	4,983						4.00
5.00	Medical Social Services	180						5.00
6.00	Home Health Aide	882						6.00
7.00	Total (sum of lines 1-6)	586,587						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 07/01/2015 To 06/30/2016	Worksheet H-3 Part II Date/Time Prepared: 7/18/2017 10:36 am
Title XVIII			Home Health Agency I	PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.254671	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	0.173088	18,475	3,198	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.569110	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1349 HHA CCN: 14-7694	Period: From 07/01/2015 To 06/30/2016	Worksheet H-4 Part I-II Date/Time Prepared: 7/18/2017 10:36 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
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
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			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
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	688,494
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	4,989
13.00	Total PPS Reimbursement - LUPA Episodes		0	7,571
14.00	Total PPS Reimbursement - PEP Episodes		0	9,639
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	0
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	710,693
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	710,693
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	710,693
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	710,693
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
31.00	Subtotal (see instructions)		0	710,693
31.01	Sequestration adjustment (see instructions)		0	0
32.00	Interim payments (see instructions)		0	710,693
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

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

Provider CCN: 14-1349
HHA CCN: 14-7694

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

Worksheet H-5
Date/Time Prepared:
7/18/2017 10:36 am
PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		710,693	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		710,693	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		710,693	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 14-1349 Component CCN: 14-3464		Period: From 07/01/2015 To 06/30/2016		Worksheet M-1 Date/Time Prepared: 7/18/2017 10:36 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	1,630,737	618,361	2,249,098	0	2,249,098	1.00
2.00	Physician Assistant	307,086	0	307,086	0	307,086	2.00
3.00	Nurse Practitioner	504,163	38,975	543,138	0	543,138	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,029,738	0	1,029,738	0	1,029,738	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	15,678	15,678	0	15,678	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	3,471,724	673,014	4,144,738	0	4,144,738	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	435,943	435,943	0	435,943	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	104,829	104,829	0	104,829	18.00
19.00	Other Health Care Costs	0	25,071	25,071	0	25,071	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	565,843	565,843	0	565,843	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,471,724	1,238,857	4,710,581	0	4,710,581	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	2,553	2,553	0	2,553	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
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	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	2,553	2,553	0	2,553	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	94,515	94,515	0	94,515	29.00
30.00	Administrative Costs	398,806	176,068	574,874	47,226	622,100	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	398,806	270,583	669,389	47,226	716,615	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,870,530	1,511,993	5,382,523	47,226	5,429,749	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1349

Period: From 07/01/2015

Worksheet M-1

Component CCN: 14-3464

To 06/30/2016

Date/Time Prepared: 7/18/2017 10:36 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	-62,777	2,186,321		1.00
2.00	Physician Assistant	0	307,086		2.00
3.00	Nurse Practitioner	0	543,138		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	1,029,738		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	15,678		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-62,777	4,081,961		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	435,943		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	104,829		18.00
19.00	Other Health Care Costs	0	25,071		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	565,843		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-62,777	4,647,804		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	2,553		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	2,553		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	94,515		29.00
30.00	Administrative Costs	-23,181	598,919		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-23,181	693,434		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-85,958	5,343,791		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1349 Component CCN: 14-3464	Period: From 07/01/2015 To 06/30/2016	Worksheet M-2 Date/Time Prepared: 7/18/2017 10:36 am
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		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	6.98	22,998	4,200	29,316	1.00
2.00	Physician Assistant	2.76	7,472	2,100	5,796	2.00
3.00	Nurse Practitioner	5.27	16,142	2,100	11,067	3.00
4.00	Subtotal (sum of lines 1 through 3)	15.01	46,612		46,179	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.18	202		202	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	15.19	46,814		46,814	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)	4,647,804	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	2,553	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	4,650,357	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.999451	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	693,434	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	3,617,981	15.00
16.00	Total overhead (sum of lines 14 and 15)	4,311,415	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	4,311,415	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	4,309,048	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	8,956,852	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1349 Component CCN: 14-3464	Period: From 07/01/2015 To 06/30/2016	Worksheet M-3 Date/Time Prepared: 7/18/2017 10:36 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)			8,956,852	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			407,914	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			8,548,938	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			46,814	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			46,814	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			182.61	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)		80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions)		182.61	182.61	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		5,967	5,967	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		1,089,634	1,089,634	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	2,179,268	16.00
16.01	Total program charges (see instructions)(from contractor's records)			1,427,359	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			46,294	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			70,680	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.)			1,563,422	16.04
16.05	Total program cost (see instructions)		0	1,634,102	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			154,311	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			245,351	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			1,634,102	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			154,315	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,788,417	22.00
23.00	Allowable bad debts (see instructions)			31,805	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			20,673	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			31,422	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
26.00	Net reimbursable amount (see instructions)			1,809,090	26.00
26.01	Sequestration adjustment (see instructions)			36,182	26.01
27.00	Interim payments			1,500,510	27.00
28.00	Tentative settlement (for contractor use only)			274,421	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)			-2,023	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 07/01/2015 To 06/30/2016	Worksheet M-4 Date/Time Prepared: 7/18/2017 10:36 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)		4,081,961	4,081,961	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000879	0.001413	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		3,588	5,768	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		167,443	34,873	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		171,031	40,641	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		4,647,804	4,647,804	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		4,309,048	4,309,048	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.036798	0.008744	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		158,564	37,678	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		329,595	78,319	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		1,065	1,713	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		309.48	45.72	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		419	539	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		129,672	24,643	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)			407,914	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)			154,315	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 07/01/2015 To 06/30/2016	Worksheet M-5 Date/Time Prepared: 7/18/2017 10:36 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		1,487,482	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01		01/28/2016	13,028	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		13,028	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,500,510	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01		02/02/2017	274,421	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)		274,421	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		2,023	6.02
7.00	Total Medicare program liability (see instructions)		1,772,908	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00