

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). OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/7/2016 10:47 am
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/7/2016 Time: 10:47 am
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GRAHAM HOSPITAL ASSOCIATION ( 140001 ) 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 XVII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	396,498	161,355	8,544	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	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	132,297	90		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		289,956		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00 Total	0	528,795	451,401	8,544	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140001		Period: From 07/01/2015 To 06/30/2016		Worksheet S-2 Part I Date/Time Prepared: 11/7/2016 9:02 am				
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 Zip Code: 61520-		4.00 County: FULTON				
1.00	Street: 210 WEST WALNUT	2.00 State: IL		3.00 Zip Code: 61520-		4.00 County: FULTON				
2.00	City: CANTON	2.00 State: IL		3.00 Zip Code: 61520-		4.00 County: FULTON				
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		
V		XVIII		XIX						
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	GRAHAM HOSPITAL ASSOCIATION	140001	99914	1	07/19/1966	N	P	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									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	GRAHAM HOSPITAL ASSOCIATION ECF	145572	99914		07/02/1987	N	P	N	9.00
10.00	Hospital-Based NF	GRAHAM HOSPITAL ASSOCIATION ECF	145572	99914		07/02/1987	N		O	10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	GRAHAM HOSPITAL HOME HEALTH AGENCY	147142	99914		06/01/1979	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	GRAHAM HOSPITAL HOSPICE	141558	99914		07/28/1993				14.00
15.00	Hospital-Based Health Clinic - RHC	COLEMAN CLINIC	143493	99914		01/01/2008	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	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)					2			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.					Y	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)					Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						2 N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,542	0	0	0	124	0		24.00	

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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
	1.00	2.00	3.00	4.00	5.00	6.00		
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.							25.00
					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.							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.							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.							35.00
					Beginning:	Ending:		
					1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.							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)							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)							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)							40.00
					V	XVIII	XIX	
					1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)							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.							46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.							47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.							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.							56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.							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)							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)							61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)							61.01

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	Y/N	IME	Direct GME	IME	Direct GME					
	1.00	2.00	3.00	4.00	5.00					
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)							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)							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).							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)							61.05		
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)							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			
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>										
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)						0.00	62.01		
<b>Teaching Hospitals that Claim Residents in Nonprovider Settings</b>										
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			

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
				1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00

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		1.00	2.00	3.00	
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
		1.00			
<b>Long Term Care Hospital PPS</b>					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
<b>TEFRA Providers</b>					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N	87.00
		V		XIX	
		1.00		2.00	
<b>Title V and XIX Services</b>					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			Y	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a critical access hospital (CAH)?		N		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)				106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				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	
<b>Miscellaneous Cost Reporting Information</b>					
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.		2		118.00

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		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	0	0	277,580
		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	
119.00	DO NOT USE THIS LINE			
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.		Y	Y
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	
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.		Y	44.00
<b>Transplant Center Information</b>				
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	
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.			
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.			
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.			
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.			
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.			
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.			
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.			
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.			
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.			
<b>All Providers</b>				
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	
		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:	
142.00	Street:	PO Box:		
143.00	City:	State:	Zip Code:	
				1.00
144.00	Are provider based physicians' costs included in Worksheet A?			Y
		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	
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	
				1.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140001		Period: From 07/01/2015 To 06/30/2016		Worksheet S-2 Part I Date/Time Prepared: 11/7/2016 9:02 am		
		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	N	161.00		
						1.00		
Multi campus								
165.00	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	166.00
						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.25	169.00	
				Beginning	Ending			
				1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			01/01/2015	12/31/2015	170.00		
						1.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)					N	171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/7/2016 9:02 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	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00	
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00	
			Y/N	Type	Date	
			1.00	2.00	3.00	
Financial Data and Reports						
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00	
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00	
			Y/N	Legal Oper.		
			1.00	2.00		
Approved Educational Activities						
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	Y	Y		6.00	
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00	
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00	
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00	
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00	
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00	
			Y/N			
			1.00			
Bad Debts						
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00	
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00	
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00	
Bed Complement						
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00	
			Part A		Part B	
			Y/N	Date	Y/N	Date
			1.00	2.00	3.00	4.00
PS&R Data						
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/21/2016	Y	09/21/2016	
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		
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		

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/7/2016 9:02 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	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
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
<b>Interest Expense</b>					
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
<b>Purchased Services</b>					
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
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N		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.		N		35.00
			Y/N	Date	
			1.00	2.00	
<b>Home Office Costs</b>					
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		
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN		LINHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563.888.4404		DAN.LINHART@RSMUS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/7/2016 9:02 am
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140001

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/7/2016 9:02 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 / Tri ps	
					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	38	13,908	0.00	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)		38	13,908	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	5	1,830	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY					0	13.00
14.00 Total (see instructions)	43.00	43	15,738	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	20	7,320		0	19.00
20.00 NURSING FACILITY	45.00	18	6,588		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			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)		81				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: 140001

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/7/2016 9:02 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)	3,164	1,084	6,519			1.00
2.00 HMO and other (see instructions)	1,227	124				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	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	3,164	1,084	6,519			7.00
8.00 INTENSIVE CARE UNIT	474	91	801			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		367	539			13.00
14.00 Total (see instructions)	3,638	1,542	7,859	0.00	451.24	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	2,378	191	3,605	0.00	16.79	19.00
20.00 NURSING FACILITY		4,247	6,302	0.00	16.96	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	1,651	223	3,182	0.00	8.81	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	2.10	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	18,875	48,687	95,247	0.00	72.49	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	568.39	27.00
28.00 Observation Bed Days		0	1,045			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			101			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: 140001

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/7/2016 9:02 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	920	435	2,170	1.00
2.00 HMO and other (see instructions)			318	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	920	435	2,170	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY	0.00					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	0.00					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

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140001		Period: From 07/01/2015 To 06/30/2016		Worksheet S-3 Part II Date/Time Prepared: 11/7/2016 9:02 am	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	29,302,144	0	29,302,144	1,182,259.35	24.78	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		797,654	0	797,654	7,450.00	107.07	3.00
4.00	Physician-Part A - Administrative		16,334	0	16,334	94.94	172.05	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		2,247,643	0	2,247,643	25,841.85	86.98	5.00
6.00	Non-physician-Part B		2,493,493	0	2,493,493	136,848.93	18.22	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	821,481	0	821,481	34,931.50	23.52	9.00
10.00	Excluded area salaries (see instructions)		2,511,158	172,061	2,683,219	107,296.43	25.01	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract labor: Direct Patient Care		1,751,174	0	1,751,174	33,609.79	52.10	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) (see instructions)		5,846,566	0	5,846,566			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		956,953	0	956,953			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		91,206	0	91,206			21.00
22.00	Physician Part A - Administrative		16,514	0	16,514			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		316,782	0	316,782			23.00
24.00	Wage-related costs (RHC/FQHC)		883,926	0	883,926			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	190,569	0	190,569	8,722.93	21.85	26.00
27.00	Administrative & General	5.00	5,783,748	0	5,783,748	227,228.31	25.45	27.00
28.00	Administrative & General under contract (see inst.)		1,383,436	0	1,383,436	11,284.27	122.60	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	835,739	-3,577	832,162	50,210.67	16.57	30.00
31.00	Laundry & Linen Service	8.00	26,759	0	26,759	2,425.45	11.03	31.00
32.00	Housekeeping	9.00	706,566	0	706,566	59,117.11	11.95	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	565,236	-331,316	233,920	17,803.81	13.14	34.00
35.00	Dietary under contract (see instructions)		257,012	0	257,012	4,492.75	57.21	35.00
36.00	Cafeteria	11.00	0	331,316	331,316	25,216.72	13.14	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	447,598	0	447,598	12,195.08	36.70	38.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140001

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
11/7/2016 9:02 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
39.00	Central Services and Supply	14.00	56,223	0	56,223	4,185.58	13.43	39.00
40.00	Pharmacy	15.00	737,996	0	737,996	25,386.71	29.07	40.00
41.00	Medical Records & Medical Records Library	16.00	475,705	0	475,705	45,920.61	10.36	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140001

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
11/7/2016 9:02 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Pai d Hours Related to Sal ari es i n col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	25,403,802	0	25,403,802	1,027,895.59	24.71	1.00
2.00	Excluded area salaries (see instructions)	3,332,639	172,061	3,504,700	142,227.93	24.64	2.00
3.00	Subtotal salaries (line 1 minus line 2)	22,071,163	-172,061	21,899,102	885,667.66	24.73	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,751,174	0	1,751,174	33,609.79	52.10	4.00
5.00	Subtotal wage-related costs (see inst.)	5,863,080	0	5,863,080	0.00	26.77	5.00
6.00	Total (sum of lines 3 thru 5)	29,685,417	-172,061	29,513,356	919,277.45	32.10	6.00
7.00	Total overhead cost (see instructions)	11,466,587	-3,577	11,463,010	494,190.00	23.20	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet S-3 Part IV Date/Time Prepared: 11/7/2016 9:02 am
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions		594,505	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		12,100	6.00
7.00	Employee Managed Care Program Administration Fees		254,598	7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		4,643,728	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		11,223	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		112,128	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		371,002	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		1,994,240	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		5,973	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		15,599	22.00
23.00	Tuition Reimbursement		96,852	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		8,111,948	24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140001

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
11/7/2016 9:02 am

Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,751,173	0	1.00
2.00	Hospital	1,304,318	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	337,286	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	109,569	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 140001 Component CCN: 147142		Period: From 07/01/2015 To 06/30/2016		Worksheet S-4 Date/Time Prepared: 11/7/2016 9:02 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County	MCLEAN				0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
<b>HOME HEALTH AGENCY STATISTICAL DATA</b>							
1.00	Home Health Aide Hours	0	686	73	1,819	2,578	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	103.00	11.00	273.00	387.00	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
<b>HOME HEALTH AGENCY - NUMBER OF EMPLOYEES</b>							
3.00	Administrator and Assistant Administrator(s)	40.00		1.43	0.00	1.43	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			2.11	0.00	2.11	5.00
6.00	Direct Nursing Service			3.72	0.00	3.72	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.86	0.86	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.39	0.39	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.05	0.05	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.31	0.00	0.31	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.24	0.00	1.24	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	HOME MAKER			0.00	0.00	0.00	18.00
<b>HOME HEALTH AGENCY CBSA CODES</b>							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20.00
20.01				37900			20.01
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	2.00	3.00	4.00	5.00
		1.00	2.00	3.00	4.00	5.00	
<b>PPS ACTIVITY DATA</b>							
21.00	Skilled Nursing Visits	665	21	27	10	723	21.00
22.00	Skilled Nursing Visit Charges	133,428	4,232	5,441	2,015	145,116	22.00
23.00	Physical Therapy Visits	330	5	23	3	361	23.00
24.00	Physical Therapy Visit Charges	72,178	1,095	5,037	657	78,967	24.00
25.00	Occupational Therapy Visits	166	8	3	2	179	25.00
26.00	Occupational Therapy Visit Charges	36,252	1,752	657	438	39,099	26.00
27.00	Speech Pathology Visits	28	0	0	2	30	27.00
28.00	Speech Pathology Visit Charges	6,132	0	0	438	6,570	28.00
29.00	Medical Social Service Visits	10	1	1	0	12	29.00
30.00	Medical Social Service Visit Charges	2,752	278	278	0	3,308	30.00
31.00	Home Health Aide Visits	334	4	0	8	346	31.00
32.00	Home Health Aide Visit Charges	42,031	505	0	1,010	43,546	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,533	39	54	25	1,651	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	292,773	7,862	11,413	4,558	316,606	35.00
36.00	Total Number of Episodes (standard/non outlier)	101		19	2	122	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	18,221	0	1,021	529	19,771	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140001

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

Worksheet S-7

Date/Time Prepared:  
11/7/2016 9:02 am

		1.00	2.00		
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N			2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	7	0	7 4.00
5.00		RVX	14	0	14 5.00
6.00		RVL	7	0	7 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	1	0	1 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	309	0	309 12.00
13.00		RUB	136	0	136 13.00
14.00		RUA	548	0	548 14.00
15.00		RVC	276	0	276 15.00
16.00		RVB	111	0	111 16.00
17.00		RVA	606	0	606 17.00
18.00		RHC	91	0	91 18.00
19.00		RHB	0	0	0 19.00
20.00		RHA	118	0	118 20.00
21.00		RMC	26	0	26 21.00
22.00		RMB	0	0	0 22.00
23.00		RMA	39	0	39 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	11	0	11 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	3	0	3 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	5	0	5 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	6	0	6 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	4	0	4 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	4	0	4 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	6	0	6 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	47	0	47 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140001

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

Worksheet S-7

Date/Time Prepared:  
11/7/2016 9:02 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	3	0	3	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		2,378	0	2,378	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	

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

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	821,481	53.01	Y	202.00
203.00	Recruitment	0	0.00	N	203.00
204.00	Retention of employees	0	0.00	N	204.00
205.00	Training	803	0.05	Y	205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	1,549,563			207.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140001 Component CCN: 143493	Period: From 07/01/2015 To 06/30/2016	Worksheet S-8 Date/Time Prepared: 11/7/2016 9:02 am			
			Rural Health Clinic (RHC) I	Cost			
1.00							
1.00	Clinic Address and Identification						
	Street	180 S MAIN STREET		1.00			
		City	State	ZIP Code			
		1.00	2.00	3.00			
2.00	City, State, ZIP Code, County		CANTON	IL	61520	2.00	
1.00							
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00	
			Grant Award	Date			
			1.00	2.00			
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)		0	4.00			
5.00	Migrant Health Center (Section 329(d), PHS Act)		0	5.00			
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		0	6.00			
7.00	Appalachian Regional Commission		0	7.00			
8.00	Look-Alikes		0	8.00			
9.00	OTHER (SPECIFY)		0	9.00			
1.00							
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0	10.00		
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11.00	Facility hours of operations (1)						
	Clinic	08:30	15:00	07:30	17:30	07:30	11.00
1.00							
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	4	13.00		
			Provider name		CCN number		
			1.00		2.00		
14.00	Provider name, CCN number		FARMINGTON CLINIC		143494	14.00	
14.01			CANTON CLINIC		143492	14.01	
14.02			CUBA CLINIC		143497	14.02	
14.03			COLEMAN CLINIC		143493	14.03	
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
County							
4.00							
2.00	City, State, ZIP Code, County		FULTON			2.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140001 Component CCN: 143493		Period: From 07/01/2015 To 06/30/2016		Worksheet S-8 Date/Time Prepared: 11/7/2016 9:02 am	
				Rural Health Clinic (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	17:30	07:30	17:30	07:30	17:30	11.00
		Friday		Saturday			
		from to		from to			
		11.00 12.00		13.00 14.00			
11.00	Facility hours of operations (1) Clinic	07:30	17:30	08:30	17:00		11.00

HOSPITAL IDENTIFICATION DATA		Provider CCN: 140001 Component CCN: 141558	Period: From 07/01/2015 To 06/30/2016	Worksheet S-9 Parts I & II Date/Time Prepared: 11/7/2016 9:02 am
		Hospice I		

	Unduplicated Days	Hospice I				Total (sum of cols. 1, 2 & 5)		
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility			
		1.00	2.00	3.00	4.00			5.00
<b>PART I - ENROLLMENT DAYS</b>								
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	1,877	32	0	0	71	1,980	2.00
3.00	Inpatient Respite Care	7	0	0	0	0	7	3.00
4.00	General Inpatient Care	0	0	0	0	0	0	4.00
5.00	Total Hospice Days	1,884	32	0	0	71	1,987	5.00
<b>Part II - CENSUS DATA</b>								
6.00	Number of Patients Receiving Hospice Care	68	4	0	0	8	80	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	27.71	8.00	0.00	0.00	8.88	24.84	8.00
9.00	Unduplicated Census Count	68	1	0	0	4	73	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet S-10 Date/Time Prepared: 11/7/2016 9:02 am	
				1.00	
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.321723	1.00	
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		3,605,998	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		3,899,475	5.00	
6.00	Medicaid charges		47,650,802	6.00	
7.00	Medicaid cost (line 1 times line 6)		15,330,359	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)		7,824,886	8.00	
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
<b>Other state or local government indigent care program (see instructions for each line)</b>					
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	
<b>Uncompensated care (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		7,824,886	19.00	
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,995,957	1,051,842	3,047,799	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	642,145	338,402	980,547	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	642,145	338,402	980,547	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		550,310	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		310,184	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		240,126	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		77,254	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,057,801	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		8,882,687	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140001

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

Worksheet A  
Date/Time Prepared:  
11/7/2016 9:02 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		6,783,828	6,783,828	-3,068,785	3,715,043	1.00
1.01	00101			0	29,040	29,040	1.01
2.00	00200		0	0	3,065,623	3,065,623	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	190,569	8,422,498	8,613,067	-25,141	8,587,926	4.00
5.00	00500	5,783,748	7,313,124	13,096,872	-87,298	13,009,574	5.00
7.00	00700	835,739	1,899,412	2,735,151	-3,577	2,731,574	7.00
8.00	00800	26,759	242,920	269,679	0	269,679	8.00
9.00	00900	706,566	153,708	860,274	0	860,274	9.00
10.00	01000	565,236	977,058	1,542,294	-904,024	638,270	10.00
11.00	01100	0	0	0	904,024	904,024	11.00
13.00	01300	447,598	20,191	467,789	0	467,789	13.00
14.00	01400	56,223	394,677	450,900	-278,865	172,035	14.00
15.00	01500	737,996	77,834	815,830	0	815,830	15.00
16.00	01600	475,705	176,282	651,987	0	651,987	16.00
20.00	02000	1,057,002	183,013	1,240,015	37,241	1,277,256	20.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,410,851	118,633	2,529,484	0	2,529,484	30.00
31.00	03100	627,010	10,568	637,578	0	637,578	31.00
43.00	04300	286,668	8,992	295,660	0	295,660	43.00
44.00	04400	821,481	40,213	861,694	0	861,694	44.00
45.00	04500	660,037	17,776	677,813	0	677,813	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,487,560	2,533,353	4,020,913	-1,689,197	2,331,716	50.00
52.00	05200	73,072	0	73,072	0	73,072	52.00
53.00	05300	797,654	758,612	1,556,266	0	1,556,266	53.00
54.00	05400	789,495	710,496	1,499,991	0	1,499,991	54.00
57.00	05700	64,633	180,814	245,447	0	245,447	57.00
58.00	05800	58,831	122,725	181,556	0	181,556	58.00
60.00	06000	1,615,329	1,787,058	3,402,387	0	3,402,387	60.00
65.00	06500	494,009	82,098	576,107	0	576,107	65.00
66.00	06600	0	1,399,291	1,399,291	0	1,399,291	66.00
71.00	07100	0	0	0	727,286	727,286	71.00
72.00	07200	0	0	0	1,240,776	1,240,776	72.00
73.00	07300	0	2,494,471	2,494,471	0	2,494,471	73.00
76.97	07697	267,066	51,811	318,877	0	318,877	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	3,625,884	9,425,833	13,051,717	-1,770,138	11,281,579	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
90.01	09001	58,402	922,949	981,351	0	981,351	90.01
91.00	09100	3,113,806	279,815	3,393,621	0	3,393,621	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	373,096	748,946	1,122,042	30,428	1,152,470	96.00
101.00	10100	484,504	193,404	677,908	4,806	682,714	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300		0	0	0	0	113.00
116.00	11600	129,462	39,926	169,388	4,806	174,194	116.00
118.00		29,121,991	48,572,329	77,694,320	-1,782,995	75,911,325	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	180,153	5,110	185,263	1,773,715	1,958,978	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	0	0	0	0	0	193.02
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	9,280	9,280	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	3,447	3,447	0	3,447	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	50,650	50,650	0	50,650	194.09
194.10	07960	0	67,403	67,403	0	67,403	194.10
200.00		29,302,144	48,698,939	78,001,083	0	78,001,083	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140001

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

Worksheet A  
Date/Time Prepared:  
11/7/2016 9:02 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100			
		-846,369	2,868,674	1.00
1.01	00101		29,040	1.01
		0		
2.00	00200	-2,491	3,063,132	2.00
3.00	00300	0	0	3.00
		0		
4.00	00400	-3,050,530	5,537,396	4.00
5.00	00500	-2,468,086	10,541,488	5.00
7.00	00700	-800	2,730,774	7.00
8.00	00800	0	269,679	8.00
9.00	00900	-1,847	858,427	9.00
10.00	01000	-195,906	442,364	10.00
11.00	01100	-448,999	455,025	11.00
13.00	01300	-3,007	464,782	13.00
14.00	01400	0	172,035	14.00
15.00	01500	-176,212	639,618	15.00
16.00	01600	-22,024	629,963	16.00
20.00	02000	-538,079	739,177	20.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	-40	2,529,444	30.00
31.00	03100	0	637,578	31.00
43.00	04300	0	295,660	43.00
44.00	04400	11,192	872,886	44.00
45.00	04500	10,072	687,885	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	-834	2,330,882	50.00
52.00	05200	0	73,072	52.00
53.00	05300	-1,497,654	58,612	53.00
54.00	05400	-300	1,499,691	54.00
57.00	05700	0	245,447	57.00
58.00	05800	0	181,556	58.00
60.00	06000	-108,651	3,293,736	60.00
65.00	06500	0	576,107	65.00
66.00	06600	0	1,399,291	66.00
71.00	07100	0	727,286	71.00
72.00	07200	0	1,240,776	72.00
73.00	07300	-80	2,494,391	73.00
76.97	07697	-30,888	287,989	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800	-7,285	11,274,294	88.00
89.00	08900	0	0	89.00
90.00	09000	0	0	90.00
90.01	09001	-88,057	893,294	90.01
91.00	09100	-2,019,131	1,374,490	91.00
92.00	09200			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	09600	-31,498	1,120,972	96.00
101.00	10100	-1,340	681,374	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	0	0	113.00
116.00	11600	0	174,194	116.00
118.00		-11,518,844	64,392,481	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	0	0	190.00
192.00	19200	0	1,958,978	192.00
193.00	19300	0	0	193.00
193.01	19301	0	0	193.01
193.02	19302	0	0	193.02
194.00	07950	0	0	194.00
194.01	07951	0	0	194.01
194.02	07952	0	0	194.02
194.03	07953	0	9,280	194.03
194.04	07954	0	0	194.04
194.05	07955	0	0	194.05
194.06	07956	0	0	194.06
194.07	07957	0	3,447	194.07
194.08	07958	0	0	194.08
194.09	07959	0	50,650	194.09
194.10	07960	0	67,403	194.10
200.00		-11,518,844	66,482,239	200.00

RECLASSIFICATIONS

Provider CCN: 140001

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

Worksheet A-6  
Date/Time Prepared:  
11/7/2016 9:02 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
<b>A - CAFETERIA RECLASS</b>						
1.00	CAFETERIA	11.00	331,316	572,708	1.00	
	TOTALS		331,316	572,708		
<b>B - MAINTENANCE LABOR RECLASS</b>						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	3,577	0	1.00	
	TOTALS		3,577	0		
<b>C - OFFSITE CAPITAL RECLASS</b>						
1.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	30,428	1.00	
2.00	RUCHFORD POB	194.03	0	8,663	2.00	
3.00	HOSPICE	116.00	0	4,806	3.00	
4.00	HOME HEALTH AGENCY	101.00	0	4,806	4.00	
	TOTALS		0	48,703		
<b>D - PROPERTY INSURANCE RECLASS</b>						
1.00	OTHER CAP REL COSTS	3.00	0	74,581	1.00	
2.00	RUCHFORD POB	194.03	0	617	2.00	
	TOTALS		0	75,198		
<b>E - DEPRECIATION RECLASS</b>						
1.00	NEW CAP REL COSTS-CARDIAC REHAB	1.01	0	22,692	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,046,060	2.00	
	TOTALS		0	3,068,752		
<b>F - RHC EXPENSE RECLASS</b>						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	168,484	1,601,654	1.00	
	TOTALS		168,484	1,601,654		
<b>H - EMPLOYEE BENEFIT AUDIT RECLASS</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	12,100	1.00	
	TOTALS		0	12,100		
<b>I - IMPLANT RECLASS</b>						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,240,776	1.00	
	TOTALS		0	1,240,776		
<b>J - MED SUP CHARGE TO PATIENTS RECLASS</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	727,286	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		0	727,286		
<b>K - NURSING SCHOOL TUITION FORGIVENESS</b>						
1.00	NURSING SCHOOL	20.00	0	37,241	1.00	
	TOTALS		0	37,241		
500.00	Grand Total: Increases		503,377	7,384,418	500.00	

		Decreases				Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
<b>A - CAFETERIA RECLASS</b>							
1.00	DIETARY	10.00	331,316	572,708	0		1.00
	TOTALS		331,316	572,708			
<b>B - MAINTENANCE LABOR RECLASS</b>							
1.00	OPERATION OF PLANT	7.00	3,577	0	0		1.00
	TOTALS		3,577	0			
<b>C - OFFSITE CAPITAL RECLASS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	48,703	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	48,703			
<b>D - PROPERTY INSURANCE RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	75,198	12		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	75,198			
<b>E - DEPRECIATION RECLASS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,068,752	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	3,068,752			
<b>F - RHC EXPENSE RECLASS</b>							
1.00	RURAL HEALTH CLINIC	88.00	168,484	1,601,654	0		1.00
	TOTALS		168,484	1,601,654			
<b>H - EMPLOYEE BENEFIT AUDIT RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,100	0		1.00
	TOTALS		0	12,100			
<b>I - IMPLANT RECLASS</b>							
1.00	OPERATING ROOM	50.00	0	1,240,776	0		1.00
	TOTALS		0	1,240,776			
<b>J - MED SUP CHARGE TO PATIENTS RECLASS</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	278,865	0		1.00
2.00	OPERATING ROOM	50.00	0	448,421	0		2.00
	TOTALS		0	727,286			
<b>K - NURSING SCHOOL TUITION FORGIVENESS</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37,241	0		1.00
	TOTALS		0	37,241			
500.00	Grand Total: Decreases		503,377	7,384,418			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140001

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
11/7/2016 9:02 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	5,050,535	33,332	0	33,332	0 1.00
2.00	Land Improvements	0	0	0	0	0 2.00
3.00	Buildings and Fixtures	64,374,472	0	0	0	21,506 3.00
4.00	Building Improvements	0	0	0	0	0 4.00
5.00	Fixed Equipment	11,827,404	0	0	0	481,614 5.00
6.00	Movable Equipment	28,658,921	66,025	0	66,025	0 6.00
7.00	HIT designated Assets	0	0	0	0	0 7.00
8.00	Subtotal (sum of lines 1-7)	109,911,332	99,357	0	99,357	503,120 8.00
9.00	Reconciling Items	-506,639	-8,813,413	0	-8,813,413	0 9.00
10.00	Total (line 8 minus line 9)	110,417,971	8,912,770	0	8,912,770	503,120 10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	5,083,867	0			0 1.00
2.00	Land Improvements	0	0			0 2.00
3.00	Buildings and Fixtures	64,352,966	0			0 3.00
4.00	Building Improvements	0	0			0 4.00
5.00	Fixed Equipment	11,345,790	0			0 5.00
6.00	Movable Equipment	28,724,946	0			0 6.00
7.00	HIT designated Assets	0	0			0 7.00
8.00	Subtotal (sum of lines 1-7)	109,507,569	0			0 8.00
9.00	Reconciling Items	-9,320,052	0			0 9.00
10.00	Total (line 8 minus line 9)	118,827,621	0			0 10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140001

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
11/7/2016 9:02 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	6,783,828	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,783,828	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	6,783,828				1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	6,783,828				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140001

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
11/7/2016 9:02 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	71,462,571	0	71,462,571	0.652581	48,670	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	9,320,052	0	9,320,052	0.085109	6,348	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	28,724,946	0	28,724,946	0.262310	19,563	2.00
3.00	Total (sum of lines 1-2)	109,507,569	0	109,507,569	1.000000	74,581	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	48,670	3,666,373	0	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0	6,348	22,692	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	19,563	3,043,569	0	2.00
3.00	Total (sum of lines 1-2)	0	0	74,581	6,732,634	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	-846,369	48,670	0	0	2,868,674	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	6,348	0	0	29,040	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	19,563	0	0	3,063,132	2.00
3.00	Total (sum of lines 1-2)	-846,369	74,581	0	0	5,960,846	3.00

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.	
			3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01 Investment income - NEW CAP REL COSTS-CARDIAC REHAB (chapter 2)			ONEW CAP REL COSTS-CARDIAC REHAB	1.01	0	1.01
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0	0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0	0.00	0	7.00
8.00 Television and radio service (chapter 21)			0	0.00	0	8.00
9.00 Parking lot (chapter 21)			0	0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,215,368			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0	0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0		0	12.00
13.00 Laundry and linen service			0	0.00	0	13.00
14.00 Cafeteria-employees and guests			0	0.00	0	14.00
15.00 Rental of quarters to employees and others			0	0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00 Sale of drugs to other than patients			0	0.00	0	17.00
18.00 Sale of medical records and abstracts			0	0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00 Vending machines			0	0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		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	0	26.00
26.01 Depreciation - NEW CAP REL COSTS-CARDIAC REHAB			ONEW CAP REL COSTS-CARDIAC REHAB	1.01	0	26.01
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			OCAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0	0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00		30.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140001

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

Worksheet A-8

Date/Time Prepared:  
11/7/2016 9:02 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 #			
			3.00	4.00	5.00		
30.99 Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99	
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00	
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00		0 32.00	
33.00 INVST INCOME-NEW BLDGS AND FIXTURES	B	-59,081	CAP REL COSTS-BLDG & FIXT	1.00	11	33.00	
33.01 GRI EMPL BENEF OTHER REVENUE	B	-110	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 33.01	
33.02 GRI HR OTHER REVENUE	B	-10	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 33.02	
33.03 TRADE, QUANTITY AND TIME DISCOUNTS	B	-16,423	ADMINISTRATIVE & GENERAL	5.00		0 33.03	
33.04		0		0.00		0 33.04	
33.05 MEDICAL STAFF DUES	B	-22,000	ADMINISTRATIVE & GENERAL	5.00		0 33.05	
33.06 OTHER INCOME & PURCHASE GROUP	B	-135,289	ADMINISTRATIVE & GENERAL	5.00		0 33.06	
33.07		0		0.00		0 33.07	
33.08 HOUSKEEPING OTHER REVENUE	B	-1,847	HOUSEKEEPING	9.00		0 33.08	
33.09 DIETARY CONSULTANT AND EMP PURCHASE	B	-188,835	DIETARY	10.00		0 33.09	
33.10 REFUND/EXP REBATE	B	-6,271	DIETARY	10.00		0 33.10	
33.11 CAFETERIA--EMPLOYEES AND GUESTS	B	-448,999	CAFETERIA	11.00		0 33.11	
33.12 NRSRG SVS CPR CLASS FEES	B	-3,007	NURSING ADMINISTRATION	13.00		0 33.12	
33.13		0		0.00		0 33.13	
33.14		0		0.00		0 33.14	
33.15 SALE OF DRUGS TO OTHER THAN PATIENTS	B	-176,218	PHARMACY	15.00		0 33.15	
33.16 REFUND/EXP REBATE	B	6	PHARMACY	15.00		0 33.16	
33.17 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-22,024	MEDICAL RECORDS & LIBRARY	16.00		0 33.17	
33.18		0		0.00		0 33.18	
33.19 LAMAZE CLASS FEES	B	-40	ADULTS & PEDIATRICS	30.00		0 33.19	
33.20		0		0.00		0 33.20	
33.21		0		0.00		0 33.21	
33.22		0		0.00		0 33.22	
33.23 MISCELLANEOUS LAB REVENUE	B	-600	LABORATORY	60.00		0 33.23	
33.24		0		0.00		0 33.24	
33.25		0		0.00		0 33.25	
33.26 CARDIAC OTHER REVENUE	B	-30,888	CARDIAC REHABILITATION	76.97		0 33.26	
33.27 RHC OTHER INCOME	B	-7,285	RURAL HEALTH CLINIC	88.00		0 33.27	
33.28 HME NON PATIENT SALES	B	-2,613	DURABLE MEDICAL EQUIP-RENTED	96.00		0 33.28	
33.29 HME HME OTHER REVENUE	B	-28,885	DURABLE MEDICAL EQUIP-RENTED	96.00		0 33.29	
33.30		0		0.00		0 33.30	
33.31		0		0.00		0 33.31	
33.32 GRI SURGERY VENDOR REBATES/REFUNDS	B	-145	OPERATING ROOM	50.00		0 33.32	
33.33		0		0.00		0 33.33	
33.34 GRI LABORATORY VENDOR REBATES/REFUND	B	-171	LABORATORY	60.00		0 33.34	
33.35		0		0.00		0 33.35	
33.36 GRI FOOD/NUTRI GUEST MEAL VOUCHERS	B	-800	DIETARY	10.00		0 33.36	
33.37 GRI BIO MED TE OTHER REVENUE	B	-800	OPERATION OF PLANT	7.00		0 33.37	
33.38		0		0.00		0 33.38	
33.39 GRI MARKETING OTHER REVENUE	B	-314	ADMINISTRATIVE & GENERAL	5.00		0 33.39	
33.40		0		0.00		0 33.40	
33.41 NURSG SCHOOL(TUITN, FEES, BOOKS, ETC.)	B	-538,079	NURSING SCHOOL	20.00		0 33.41	
33.42 DONATIONS & DUES	A	-12,712	ADMINISTRATIVE & GENERAL	5.00		0 33.42	
33.43 CRNA SALARY EXPENSE	A	-797,654	ANESTHESIOLOGY	53.00		0 33.43	
33.44 CRNA BENEFIT EXPENSE	A	-23,177	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 33.44	
33.45 CRNA CONTRACTED EXPENSE	A	-700,000	ANESTHESIOLOGY	53.00		0 33.45	
33.46		0		0.00		0 33.46	
33.47 IL PROVIDER PARTICIPATION FEE	A	11,192	SKILLED NURSING FACILITY	44.00		0 33.47	
33.48 IL PROVIDER PARTICIPATION FEE	A	10,072	NURSING FACILITY	45.00		0 33.48	

Provider CCN: 140001  
Period: From 07/01/2015 To 06/30/2016  
Worksheet A-8  
Date/Time Prepared: 11/7/2016 9:02 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
33.49 IL HOSPITAL PROVIDER TAX	A	-1,767,987	ADMINISTRATIVE & GENERAL	5.00	0	33.49
33.50 TELEVISION AND RADIO SERVICE	A	-2,058	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.50
33.51 PHONE SALARIES EXPENSE	A	-4,444	ADMINISTRATIVE & GENERAL	5.00	0	33.51
33.52 PHONE BENEFIT EXPENSE	A	-704	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.52
33.53 PHONE OTHER EXPENSE	A	-4,741	ADMINISTRATIVE & GENERAL	5.00	0	33.53
33.54 PHONE DEPRECIATION M/M EXPENSE	A	-433	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.54
33.55 IHA & AHA DUES LOBBYING PORTION	A	-31,650	ADMINISTRATIVE & GENERAL	5.00	0	33.55
33.56		0		0.00	0	33.56
33.57 IL HOMECARE COUNCIL LOBBYING	A	-1,340	HOME HEALTH AGENCY	101.00	0	33.57
33.58 MARKETING DEPT SALARY EXPENSE	A	-118,699	ADMINISTRATIVE & GENERAL	5.00	0	33.58
33.59 MARKETING DEPT BENEFIT EXPENSE	A	-12,294	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.59
33.60 MARKETING DEPT OTHER EXPENSE	A	-215,718	ADMINISTRATIVE & GENERAL	5.00	0	33.60
33.61 MARKETING DRUGS AND PHARMCEUTICALS	A	-80	DRUGS CHARGED TO PATIENTS	73.00	0	33.61
33.62 PHYSICIAN RECRUITMENT	A	-138,109	ADMINISTRATIVE & GENERAL	5.00	0	33.62
33.63 LOAN FORGIVENESS EXPENSE	A	-137,817	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.63
33.64 ER PHYSICIAN BENEFITS	A	-37,378	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.64
33.65 SELF INSURANCE COSTS	A	-2,839,040	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.65
33.66 SWAP INTEREST RATE EXPENSE	A	-787,288	CAP REL COSTS-BLDG & FIXT	1.00	11	33.66
33.67 GRI SURGERY OTHER REVENUE	B	-689	OPERATING ROOM	50.00	0	33.67
33.68		0		0.00	0	33.68
33.69		0		0.00	0	33.69
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,518,844				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: 140001

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

Worksheet A-8-2

Date/Time Prepared:  
11/7/2016 9:02 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	91.00	EMERGENCY	1,956,624	1,940,290	16,334	159,800	95	1.00
2.00	91.00	EMERGENCY	69,806	69,806	0	0	0	2.00
3.00	60.00	LABORATORY	57,600	57,600	0	0	0	3.00
4.00	60.00	LABORATORY	50,280	50,280	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	300	300	0	0	0	6.00
7.00	90.01	WOUND CLINIC	88,057	88,057	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			2,222,667	2,206,333	16,334		95	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	7,299	365	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	90.01	WOUND CLINIC	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			7,299	365	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	7,299	9,035	1,949,325		1.00
2.00	91.00	EMERGENCY	0	0	0	69,806		2.00
3.00	60.00	LABORATORY	0	0	0	57,600		3.00
4.00	60.00	LABORATORY	0	0	0	50,280		4.00
5.00	0.00		0	0	0	0		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	300		6.00
7.00	90.01	WOUND CLINIC	0	0	0	88,057		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	7,299	9,035	2,215,368		200.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part I Date/Time Prepared: 11/7/2016 9:02 am
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	NEW CARDIAC REHAB	MVBLE EQUIP		
	0	1.00	1.01	2.00	4.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,868,674	2,868,674			1.00
1.01 00101	NEW CAP REL COSTS-CARDIAC REHAB	29,040	0	29,040		1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP	3,063,132			3,063,132	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,537,396	18,271	0	894	5,556,561 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	10,541,488	308,423	0	1,559,278	1,198,959 5.00
7.00 00700	OPERATION OF PLANT	2,730,774	328,928	0	45,708	176,257 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	269,679	33,291	0	1,797	5,668 8.00
9.00 00900	HOUSEKEEPING	858,427	34,030	0	9,171	149,655 9.00
10.00 01000	DIETARY	442,364	85,954	0	20,591	49,546 10.00
11.00 01100	CAFETERIA	455,025	22,977	0	0	70,175 11.00
13.00 01300	NURSING ADMINISTRATION	464,782	26,237	0	4,262	94,804 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	172,035	0	0	1,816	11,908 14.00
15.00 01500	PHARMACY	639,618	19,651	0	70,963	156,312 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	629,963	73,061	0	3,767	100,757 16.00
20.00 02000	NURSING SCHOOL	739,177	256,639	0	43,118	223,879 20.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	2,529,444	177,065	0	106,949	510,633 30.00
31.00 03100	INTENSIVE CARE UNIT	637,578	30,893	0	11,716	132,804 31.00
43.00 04300	NURSERY	295,660	8,959	0	5,013	60,718 43.00
44.00 04400	SKILLED NURSING FACILITY	872,886	74,975	0	4,353	173,995 44.00
45.00 04500	NURSING FACILITY	687,885	54,051	0	4,463	139,800 45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	2,330,882	174,134	0	440,008	315,074 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	73,072	26,549	0	0	15,477 52.00
53.00 05300	ANESTHESIOLOGY	58,612	10,454	0	18,151	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,499,691	94,248	0	251,355	167,220 54.00
57.00 05700	CT SCAN	245,447	0	0	90,064	13,690 57.00
58.00 05800	MRI	181,556	24,595	0	64,146	12,461 58.00
60.00 06000	LABORATORY	3,293,736	133,271	0	105,894	342,136 60.00
65.00 06500	RESPIRATORY THERAPY	576,107	1,610	0	21,178	104,634 65.00
66.00 06600	PHYSICAL THERAPY	1,399,291	51,365	0	3,097	0 66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	727,286	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	1,240,776	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,494,391	0	0	0	0 73.00
76.97 07697	CARDIAC REHABILITATION	287,989	0	29,040	17,023	56,566 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	11,274,294	426,987	0	70,822	732,298 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00 09000	CLINIC	0	0	0	0	0 90.00
90.01 09001	WOUND CLINIC	893,294	27,485	0	447	12,370 90.01
91.00 09100	EMERGENCY	1,374,490	108,364	0	39,910	245,098 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	1,120,972	0	0	32,081	79,024 96.00
101.00 10100	HOME HEALTH AGENCY	681,374	0	0	12,870	102,621 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	174,194	0	0	0	27,421 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	64,392,481	2,632,467	29,040	3,060,905	5,481,960 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,994	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,958,978	99,323	0	2,227	74,601 192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
193.01 19301	NONPAID WORKERS	0	0	0	0	0 193.01
193.02 19302	FOUNDATION	0	0	0	0	0 193.02
194.00 07950	PHYSICIANS CLINIC	0	22,821	0	0	0 194.00
194.01 07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0 194.01
194.02 07952	FRESENIUS	0	49,271	0	0	0 194.02
194.03 07953	RUCHFORD POB	9,280	0	0	0	0 194.03
194.04 07954	EP COLEMAN RENTAL SPACE	0	54,798	0	0	0 194.04
194.05 07955	FARMINGTON POB	0	0	0	0	0 194.05
194.06 07956	LEWISTON POB	0	0	0	0	0 194.06
194.07 07957	OTHER RENTAL PROPERTY	3,447	0	0	0	0 194.07
194.08 07958	KELLEY HOME	0	0	0	0	0 194.08
194.09 07959	EMPLOYEE PURCHASE	50,650	0	0	0	0 194.09
194.10 07960	RETAIL PHARMACY	67,403	0	0	0	0 194.10
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	0 201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140001

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/7/2016 9:02 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	NEW CARDIAC REHAB	MVBLE EQUIP		
202.00   TOTAL (sum lines 118-201)	66,482,239	2,868,674	29,040	3,063,132	5,556,561	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140001

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/7/2016 9:02 am

Cost Center Description			Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						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	13,608,148	13,608,148				5.00
7.00	00700	OPERATION OF PLANT	3,281,667	844,599	4,126,266			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	310,435	79,896	62,072	452,403		8.00
9.00	00900	HOUSEKEEPING	1,051,283	270,568	63,450	9,030	1,394,331	9.00
10.00	01000	DIETARY	598,455	154,024	160,263	0	80,262	10.00
11.00	01100	CAFETERIA	548,177	141,084	42,841	0	21,455	11.00
13.00	01300	NURSING ADMINISTRATION	590,085	151,870	48,919	0	24,500	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	185,759	47,809	0	0	0	14.00
15.00	01500	PHARMACY	886,544	228,169	36,640	0	18,350	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	807,548	207,838	136,224	0	36,462	16.00
20.00	02000	NURSING SCHOOL	1,262,813	325,009	478,506	696	239,644	20.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	3,324,091	855,518	330,140	158,479	165,340	30.00
31.00	03100	INTENSIVE CARE UNIT	812,991	209,239	57,601	14,643	28,847	31.00
43.00	04300	NURSERY	370,350	95,317	16,705	2,171	8,366	43.00
44.00	04400	SKILLED NURSING FACILITY	1,126,209	289,851	139,791	56,448	70,010	44.00
45.00	04500	NURSING FACILITY	886,199	228,080	100,778	51,040	50,472	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	3,260,098	839,048	324,674	60,478	162,602	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	115,098	29,623	49,501	0	24,791	52.00
53.00	05300	ANESTHESIOLOGY	87,217	22,447	19,491	0	9,762	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,012,514	517,959	175,727	26,132	78,475	54.00
57.00	05700	CT SCAN	349,201	89,874	0	0	0	57.00
58.00	05800	MRI	282,758	72,773	45,857	0	22,966	58.00
60.00	06000	LABORATORY	3,875,037	997,314	248,486	1,031	96,457	60.00
65.00	06500	RESPIRATORY THERAPY	703,529	181,067	3,001	432	1,503	65.00
66.00	06600	PHYSICAL THERAPY	1,453,753	374,151	95,772	10,146	47,964	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	727,286	187,181	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,240,776	319,337	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,494,391	641,979	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	390,618	100,533	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	12,504,401	3,218,241	796,121	971	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	933,596	240,279	51,247	7,531	25,665	90.01
91.00	09100	EMERGENCY	1,767,862	454,993	202,047	53,175	101,188	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,232,077	317,098	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	796,865	205,088	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	201,615	51,889	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	64,079,446	12,989,745	3,685,854	452,403	1,315,081	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,994	2,572	18,634	0	9,332	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,135,129	549,516	185,189	0	48,608	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	22,821	5,873	42,550	0	21,310	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	49,271	12,681	91,867	0	0	194.02
194.03	07953	RUCHFORD POB	9,280	2,388	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	54,798	14,103	102,172	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	3,447	887	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	50,650	13,036	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	67,403	17,347	0	0	0	194.10
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	66,482,239	13,608,148	4,126,266	452,403	1,394,331	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140001

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/7/2016 9:02 am

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	993,004					10.00
11.00	01100	0	753,557				11.00
13.00	01300	0	15,936	831,310			13.00
14.00	01400	0	5,466	0	239,034		14.00
15.00	01500	0	33,206	0	1,093	1,204,002	15.00
16.00	01600	0	60,047	0	0	0	16.00
20.00	02000	0	44,628	0	86	208	20.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	412,282	128,689	294,531	3,125	538	30.00
31.00	03100	46,396	24,557	56,205	686	91	31.00
43.00	04300	0	9,002	20,602	544	0	43.00
44.00	04400	194,604	45,661	104,505	893	34	44.00
45.00	04500	339,722	46,123	105,563	473	181	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	69,457	158,967	29,119	5,453	50.00
52.00	05200	0	4,025	0	0	0	52.00
53.00	05300	0	9,736	22,283	641	519	53.00
54.00	05400	0	39,270	0	481	3,131	54.00
57.00	05700	0	2,774	0	368	103	57.00
58.00	05800	0	2,720	0	9	0	58.00
60.00	06000	0	116,940	0	7,298	647	60.00
65.00	06500	0	19,418	0	1,028	887	65.00
66.00	06600	0	0	0	370	42	66.00
71.00	07100	0	0	0	58,276	0	71.00
72.00	07200	0	0	0	99,352	0	72.00
73.00	07300	0	0	0	0	872,046	73.00
76.97	07697	0	11,640	0	187	289	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	16,279	308,056	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	326	747	11,704	2,867	90.01
91.00	09100	0	63,936	0	3,265	2,085	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	0	0	0	0	70	96.00
101.00	10100	0	0	54,836	866	29	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	0	0	0	0	113.00
116.00	11600	0	0	13,071	0	6,398	116.00
118.00		993,004	753,557	831,310	236,143	1,203,674	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	21	328	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	0	0	0	0	0	193.02
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	2,870	0	194.09
194.10	07960	0	0	0	0	0	194.10
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		993,004	753,557	831,310	239,034	1,204,002	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140001

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/7/2016 9:02 am

Cost Center Description		MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	20.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB					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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,248,119				16.00
20.00	02000	NURSING SCHOOL	0	2,351,590			20.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	509,820	1,196,179	7,378,732	0	7,378,732
31.00	03100	INTENSIVE CARE UNIT	55,780	136,399	1,443,435	0	1,443,435
43.00	04300	NURSERY	36,371	0	559,428	0	559,428
44.00	04400	SKILLED NURSING FACILITY	25,989	182,713	2,236,708	0	2,236,708
45.00	04500	NURSING FACILITY	45,365	0	1,853,996	0	1,853,996
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	58,359	261,904	5,230,159	0	5,230,159
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	223,038	0	223,038
53.00	05300	ANESTHESIOLOGY	0	0	172,096	0	172,096
54.00	05400	RADIOLOGY-DIAGNOSTIC	234,725	0	3,088,414	0	3,088,414
57.00	05700	CT SCAN	0	0	442,320	0	442,320
58.00	05800	MRI	0	0	427,083	0	427,083
60.00	06000	LABORATORY	146,509	0	5,489,719	0	5,489,719
65.00	06500	RESPIRATORY THERAPY	0	15,014	925,879	0	925,879
66.00	06600	PHYSICAL THERAPY	0	7,700	1,989,898	0	1,989,898
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	972,743	0	972,743
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,659,465	0	1,659,465
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,700	4,016,116	0	4,016,116
76.97	07697	CARDIAC REHABILITATION	0	48,700	551,967	0	551,967
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	62,560	16,906,629	0	16,906,629
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	WOUND CLINIC	0	128,392	1,402,354	0	1,402,354
91.00	09100	EMERGENCY	135,201	151,491	2,935,243	0	2,935,243
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	1,549,245	0	1,549,245
101.00	10100	HOME HEALTH AGENCY	0	102,020	1,159,704	0	1,159,704
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	50,818	323,791	0	323,791
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,248,119	2,351,590	62,938,162	0	62,938,162
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	40,532	0	40,532
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,918,791	0	2,918,791
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	NONPAID WORKERS	0	0	0	0	0
193.02	19302	FOUNDATION	0	0	0	0	0
194.00	07950	PHYSICIANS CLINIC	0	0	92,554	0	92,554
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0
194.02	07952	FRESENIUS	0	0	153,819	0	153,819
194.03	07953	RUCHFORD POB	0	0	11,668	0	11,668
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	171,073	0	171,073
194.05	07955	FARMINGTON POB	0	0	0	0	0
194.06	07956	LEWISTON POB	0	0	0	0	0
194.07	07957	OTHER RENTAL PROPERTY	0	0	4,334	0	4,334
194.08	07958	KELLEY HOME	0	0	0	0	0
194.09	07959	EMPLOYEE PURCHASE	0	0	66,556	0	66,556
194.10	07960	RETAIL PHARMACY	0	0	84,750	0	84,750
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,248,119	2,351,590	66,482,239	0	66,482,239

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 11/7/2016 9:02 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal		
		BLDG & FIXT	NEW CARDIAC REHAB	MVBLE EQUIP			
		0	1.00	1.01		2.00	2A
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00		
1.01 00101	NEW CAP REL COSTS-CARDIAC REHAB				1.01		
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00		
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	18,271	0	894	19,165	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	308,423	0	1,559,278	1,867,701	5.00
7.00 00700	OPERATION OF PLANT	0	328,928	0	45,708	374,636	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	33,291	0	1,797	35,088	8.00
9.00 00900	HOUSEKEEPING	0	34,030	0	9,171	43,201	9.00
10.00 01000	DIETARY	0	85,954	0	20,591	106,545	10.00
11.00 01100	CAFETERIA	0	22,977	0	0	22,977	11.00
13.00 01300	NURSING ADMINISTRATION	0	26,237	0	4,262	30,499	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,816	1,816	14.00
15.00 01500	PHARMACY	0	19,651	0	70,963	90,614	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	73,061	0	3,767	76,828	16.00
20.00 02000	NURSING SCHOOL	0	256,639	0	43,118	299,757	20.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	0	177,065	0	106,949	284,014	30.00
31.00 03100	INTENSIVE CARE UNIT	0	30,893	0	11,716	42,609	31.00
43.00 04300	NURSERY	0	8,959	0	5,013	13,972	43.00
44.00 04400	SKILLED NURSING FACILITY	0	74,975	0	4,353	79,328	44.00
45.00 04500	NURSING FACILITY	0	54,051	0	4,463	58,514	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	0	174,134	0	440,008	614,142	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	26,549	0	0	26,549	52.00
53.00 05300	ANESTHESIOLOGY	0	10,454	0	18,151	28,605	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	94,248	0	251,355	345,603	54.00
57.00 05700	CT SCAN	0	0	0	90,064	90,064	57.00
58.00 05800	MRI	0	24,595	0	64,146	88,741	58.00
60.00 06000	LABORATORY	0	133,271	0	105,894	239,165	60.00
65.00 06500	RESPIRATORY THERAPY	0	1,610	0	21,178	22,788	65.00
66.00 06600	PHYSICAL THERAPY	0	51,365	0	3,097	54,462	66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97 07697	CARDIAC REHABILITATION	0	0	29,040	17,023	46,063	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800	RURAL HEALTH CLINIC	0	426,987	0	70,822	497,809	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	0	90.00
90.01 09001	WOUND CLINIC	0	27,485	0	447	27,932	90.01
91.00 09100	EMERGENCY	0	108,364	0	39,910	148,274	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	32,081	32,081	96.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	12,870	12,870	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300	INTEREST EXPENSE						113.00
116.00 11600	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,632,467	29,040	3,060,905	5,722,412	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,994	0	0	9,994	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	99,323	0	2,227	101,550	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02 19302	FOUNDATION	0	0	0	0	0	193.02
194.00 07950	PHYSICIANS CLINIC	0	22,821	0	0	22,821	194.00
194.01 07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02 07952	FRESENIUS	0	49,271	0	0	49,271	194.02
194.03 07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04 07954	EP COLEMAN RENTAL SPACE	0	54,798	0	0	54,798	194.04
194.05 07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06 07956	LEWISTON POB	0	0	0	0	0	194.06
194.07 07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08 07958	KELLEY HOME	0	0	0	0	0	194.08
194.09 07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10 07960	RETAIL PHARMACY	0	0	0	0	0	194.10
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	TOTAL (sum lines 118-201)	0	2,868,674	29,040	3,063,132	5,960,846	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 11/7/2016 9:02 am		
Cost Center	Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4.00	5.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	19,165				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,128	1,871,829			5.00
7.00	00700	OPERATION OF PLANT	608	116,178	491,422		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20	10,990	7,392	53,490	8.00
9.00	00900	HOUSEKEEPING	516	37,218	7,557	1,068	89,560
10.00	01000	DIETARY	171	21,187	19,087	0	5,155
11.00	01100	CAFETERIA	242	19,407	5,102	0	1,378
13.00	01300	NURSING ADMINISTRATION	327	20,890	5,826	0	1,574
14.00	01400	CENTRAL SERVICES & SUPPLY	41	6,576	0	0	0
15.00	01500	PHARMACY	539	31,385	4,364	0	1,179
16.00	01600	MEDICAL RECORDS & LIBRARY	348	28,589	16,224	0	2,342
20.00	02000	NURSING SCHOOL	773	44,706	56,988	82	15,392
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,762	117,679	39,318	18,737	10,620
31.00	03100	INTENSIVE CARE UNIT	458	28,782	6,860	1,731	1,853
43.00	04300	NURSERY	210	13,111	1,989	257	537
44.00	04400	SKILLED NURSING FACILITY	601	39,870	16,649	6,674	4,497
45.00	04500	NURSING FACILITY	482	31,373	12,002	6,035	3,242
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,087	115,414	38,667	7,151	10,444
52.00	05200	DELIVERY ROOM & LABOR ROOM	53	4,075	5,895	0	1,592
53.00	05300	ANESTHESIOLOGY	0	3,088	2,321	0	627
54.00	05400	RADIOLOGY-DIAGNOSTIC	577	71,247	20,928	3,090	5,041
57.00	05700	CT SCAN	47	12,362	0	0	0
58.00	05800	MRI	43	10,010	5,461	0	1,475
60.00	06000	LABORATORY	1,181	137,184	29,594	122	6,196
65.00	06500	RESPIRATORY THERAPY	361	24,906	357	51	97
66.00	06600	PHYSICAL THERAPY	0	51,466	11,406	1,200	3,081
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	25,747	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	43,926	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	88,306	0	0	0
76.97	07697	CARDIAC REHABILITATION	195	13,829	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	2,527	442,660	94,818	115	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	WOUND CLINIC	43	33,051	6,103	890	1,649
91.00	09100	EMERGENCY	846	62,586	24,063	6,287	6,499
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	273	43,618	0	0	0
101.00	10100	HOME HEALTH AGENCY	354	28,211	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	95	7,138	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,908	1,786,765	438,971	53,490	84,470
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	354	2,219	0	599
192.00	19200	PHYSICIANS' PRIVATE OFFICES	257	75,588	22,055	0	3,122
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	NONPAID WORKERS	0	0	0	0	0
193.02	19302	FOUNDATION	0	0	0	0	0
194.00	07950	PHYSICIANS CLINIC	0	808	5,068	0	1,369
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0
194.02	07952	FRESENIUS	0	1,744	10,941	0	0
194.03	07953	RUCHFORD POB	0	329	0	0	0
194.04	07954	EP COLEMAN RENTAL SPACE	0	1,940	12,168	0	0
194.05	07955	FARMINGTON POB	0	0	0	0	0
194.06	07956	LEWISTON POB	0	0	0	0	0
194.07	07957	OTHER RENTAL PROPERTY	0	122	0	0	0
194.08	07958	KELLEY HOME	0	0	0	0	0
194.09	07959	EMPLOYEE PURCHASE	0	1,793	0	0	0
194.10	07960	RETAIL PHARMACY	0	2,386	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	19,165	1,871,829	491,422	53,490	89,560

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140001		Period: From 07/01/2015 To 06/30/2016		Worksheet B Part II Date/Time Prepared: 11/7/2016 9:02 am	
Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	152,145					10.00
11.00	01100	0	49,106				11.00
13.00	01300	0	1,039	60,155			13.00
14.00	01400	0	356	0	8,789		14.00
15.00	01500	0	2,164	0	40	130,285	15.00
16.00	01600	0	3,913	0	0	0	16.00
20.00	02000	0	2,908	0	3	23	20.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	63,168	8,387	21,313	115	58	30.00
31.00	03100	7,109	1,600	4,067	25	10	31.00
43.00	04300	0	587	1,491	20	0	43.00
44.00	04400	29,817	2,976	7,562	33	4	44.00
45.00	04500	52,051	3,006	7,639	17	20	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	4,526	11,503	1,071	590	50.00
52.00	05200	0	262	0	0	0	52.00
53.00	05300	0	634	1,612	24	56	53.00
54.00	05400	0	2,559	0	18	339	54.00
57.00	05700	0	181	0	14	11	57.00
58.00	05800	0	177	0	0	0	58.00
60.00	06000	0	7,620	0	268	70	60.00
65.00	06500	0	1,265	0	38	96	65.00
66.00	06600	0	0	0	14	4	66.00
71.00	07100	0	0	0	2,143	0	71.00
72.00	07200	0	0	0	3,651	0	72.00
73.00	07300	0	0	0	0	94,364	73.00
76.97	07697	0	759	0	7	31	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	599	33,335	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	21	54	430	310	90.01
91.00	09100	0	4,166	0	120	226	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	0	0	0	0	8	96.00
101.00	10100	0	0	3,968	32	3	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	0	0	0	0	113.00
116.00	11600	0	0	946	0	692	116.00
118.00		152,145	49,106	60,155	8,682	130,250	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	1	35	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	0	0	0	0	0	193.02
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	106	0	194.09
194.10	07960	0	0	0	0	0	194.10
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		152,145	49,106	60,155	8,789	130,285	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 11/7/2016 9:02 am
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Cost Center Description		MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	20.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB					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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	128,244				16.00
20.00	02000	NURSING SCHOOL	0	420,632			20.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	52,385		617,556	0	617,556
31.00	03100	INTENSIVE CARE UNIT	5,731		100,835	0	100,835
43.00	04300	NURSERY	3,737		35,911	0	35,911
44.00	04400	SKILLED NURSING FACILITY	2,670		190,681	0	190,681
45.00	04500	NURSING FACILITY	4,661		179,042	0	179,042
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	5,996		810,591	0	810,591
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		38,426	0	38,426
53.00	05300	ANESTHESIOLOGY	0		36,967	0	36,967
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,118		473,520	0	473,520
57.00	05700	CT SCAN	0		102,679	0	102,679
58.00	05800	MRI	0		105,907	0	105,907
60.00	06000	LABORATORY	15,054		436,454	0	436,454
65.00	06500	RESPIRATORY THERAPY	0		49,959	0	49,959
66.00	06600	PHYSICAL THERAPY	0		121,633	0	121,633
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		27,890	0	27,890
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		47,577	0	47,577
73.00	07300	DRUGS CHARGED TO PATIENTS	0		182,670	0	182,670
76.97	07697	CARDIAC REHABILITATION	0		60,884	0	60,884
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0		1,071,863	0	1,071,863
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0
90.00	09000	CLINIC	0		0	0	0
90.01	09001	WOUND CLINIC	0		70,483	0	70,483
91.00	09100	EMERGENCY	13,892		266,959	0	266,959
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		75,980	0	75,980
101.00	10100	HOME HEALTH AGENCY	0		45,438	0	45,438
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE	0		0	0	0
116.00	11600	HOSPICE	0		8,871	0	8,871
118.00		SUBTOTALS (SUM OF LINES 1-117)	128,244	0	5,158,776	0	5,158,776
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		13,166	0	13,166
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		202,608	0	202,608
193.00	19300	NONPAID WORKERS	0		0	0	0
193.01	19301	NONPAID WORKERS	0		0	0	0
193.02	19302	FOUNDATION	0		0	0	0
194.00	07950	PHYSICIANS CLINIC	0		30,066	0	30,066
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0		0	0	0
194.02	07952	FRESENIUS	0		61,956	0	61,956
194.03	07953	RUCHFORD POB	0		329	0	329
194.04	07954	EP COLEMAN RENTAL SPACE	0		68,906	0	68,906
194.05	07955	FARMINGTON POB	0		0	0	0
194.06	07956	LEWISTON POB	0		0	0	0
194.07	07957	OTHER RENTAL PROPERTY	0		122	0	122
194.08	07958	KELLEY HOME	0		0	0	0
194.09	07959	EMPLOYEE PURCHASE	0		1,899	0	1,899
194.10	07960	RETAIL PHARMACY	0		2,386	0	2,386
200.00		Cross Foot Adjustments		420,632	420,632	0	420,632
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	128,244	420,632	5,960,846	0	5,960,846

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140001

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

Worksheet B-1  
Date/Time Prepared:  
11/7/2016 9:02 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	
	BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
	1.00	1.01	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	349,331				1.00
1.01 00101	NEW CAP REL COSTS-CARDIAC REHAB	0	30,653			1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP			3,046,063		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,225	0	889	26,234,154	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	37,558	0	1,550,588	5,660,605	-13,608,148
7.00 00700	OPERATION OF PLANT	40,055	0	45,453	832,162	0
8.00 00800	LAUNDRY & LINEN SERVICE	4,054	0	1,787	26,759	0
9.00 00900	HOUSEKEEPING	4,144	0	9,120	706,566	0
10.00 01000	DIETARY	10,467	0	20,476	233,920	0
11.00 01100	CAFETERIA	2,798	0	0	331,316	0
13.00 01300	NURSING ADMINISTRATION	3,195	0	4,238	447,598	0
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	1,806	56,223	0
15.00 01500	PHARMACY	2,393	0	70,568	737,996	0
16.00 01600	MEDICAL RECORDS & LIBRARY	8,897	0	3,746	475,705	0
20.00 02000	NURSING SCHOOL	31,252	0	42,878	1,057,002	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	21,562	0	106,353	2,410,851	0
31.00 03100	INTENSIVE CARE UNIT	3,762	0	11,651	627,010	0
43.00 04300	NURSERY	1,091	0	4,985	286,668	0
44.00 04400	SKILLED NURSING FACILITY	9,130	0	4,329	821,481	0
45.00 04500	NURSING FACILITY	6,582	0	4,438	660,037	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	21,205	0	437,556	1,487,560	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,233	0	0	73,072	0
53.00 05300	ANESTHESIOLOGY	1,273	0	18,050	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	11,477	0	249,954	789,495	0
57.00 05700	CT SCAN	0	0	89,562	64,633	0
58.00 05800	MRI	2,995	0	63,789	58,831	0
60.00 06000	LABORATORY	16,229	0	105,304	1,615,329	0
65.00 06500	RESPIRATORY THERAPY	196	0	21,060	494,009	0
66.00 06600	PHYSICAL THERAPY	6,255	0	3,080	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.97 07697	CARDIAC REHABILITATION	0	30,653	16,928	267,066	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	51,996	0	70,427	3,457,400	0
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00 09000	CLINIC	0	0	0	0	0
90.01 09001	WOUND CLINIC	3,347	0	445	58,402	0
91.00 09100	EMERGENCY	13,196	0	39,688	1,157,182	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	31,902	373,096	0
101.00 10100	HOME HEALTH AGENCY	0	0	12,798	484,504	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	0	0	0	129,462	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	320,567	30,653	3,043,848	25,881,940	-13,608,148
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,217	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	12,095	0	2,215	352,214	0
193.00 19300	NONPAID WORKERS	0	0	0	0	0
193.01 19301	NONPAID WORKERS	0	0	0	0	0
193.02 19302	FOUNDATION	0	0	0	0	0
194.00 07950	PHYSICIANS CLINIC	2,779	0	0	0	0
194.01 07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0
194.02 07952	FRESENIUS	6,000	0	0	0	0
194.03 07953	RUCHFORD POB	0	0	0	0	0
194.04 07954	EP COLEMAN RENTAL SPACE	6,673	0	0	0	0
194.05 07955	FARMINGTON POB	0	0	0	0	0
194.06 07956	LEWISTON POB	0	0	0	0	0
194.07 07957	OTHER RENTAL PROPERTY	0	0	0	0	0
194.08 07958	KELLEY HOME	0	0	0	0	0
194.09 07959	EMPLOYEE PURCHASE	0	0	0	0	0
194.10 07960	RETAIL PHARMACY	0	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140001

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

Worksheet B-1  
Date/Time Prepared:  
11/7/2016 9:02 am

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	Reconciliation	
		BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
		1.00	1.01	2.00			
202.00	Cost to be allocated (per Wkst. B, Part I)	2,868,674	29,040	3,063,132	5,556,561		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8.211908	0.947379	1.005604	0.211806		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				19,165		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.000731		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140001

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

Worksheet B-1

Date/Time Prepared:  
11/7/2016 9:02 am

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB					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	52,874,091				5.00
7.00	00700	OPERATION OF PLANT	3,281,667	269,493			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	310,435	4,054	980,824		8.00
9.00	00900	HOUSEKEEPING	1,051,283	4,144	19,578	181,835	9.00
10.00	01000	DIETARY	598,455	10,467	0	10,467	55,262
11.00	01100	CAFETERIA	548,177	2,798	0	2,798	0
13.00	01300	NURSING ADMINISTRATION	590,085	3,195	0	3,195	0
14.00	01400	CENTRAL SERVICES & SUPPLY	185,759	0	0	0	0
15.00	01500	PHARMACY	886,544	2,393	0	2,393	0
16.00	01600	MEDICAL RECORDS & LIBRARY	807,548	8,897	0	4,755	0
20.00	02000	NURSING SCHOOL	1,262,813	31,252	1,508	31,252	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	3,324,091	21,562	343,590	21,562	22,944
31.00	03100	INTENSIVE CARE UNIT	812,991	3,762	31,746	3,762	2,582
43.00	04300	NURSERY	370,350	1,091	4,706	1,091	0
44.00	04400	SKILLED NURSING FACILITY	1,126,209	9,130	122,382	9,130	10,830
45.00	04500	NURSING FACILITY	886,199	6,582	110,656	6,582	18,906
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	3,260,098	21,205	131,118	21,205	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	115,098	3,233	0	3,233	0
53.00	05300	ANESTHESIOLOGY	87,217	1,273	0	1,273	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,012,514	11,477	56,654	10,234	0
57.00	05700	CT SCAN	349,201	0	0	0	0
58.00	05800	MRI	282,758	2,995	0	2,995	0
60.00	06000	LABORATORY	3,875,037	16,229	2,236	12,579	0
65.00	06500	RESPIRATORY THERAPY	703,529	196	936	196	0
66.00	06600	PHYSICAL THERAPY	1,453,753	6,255	21,996	6,255	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	727,286	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,240,776	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,494,391	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	390,618	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	12,504,401	51,996	2,106	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	WOUND CLINIC	933,596	3,347	16,328	3,347	0
91.00	09100	EMERGENCY	1,767,862	13,196	115,284	13,196	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,232,077	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	796,865	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	201,615	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	50,471,298	240,729	980,824	171,500	55,262
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,994	1,217	0	1,217	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,135,129	12,095	0	6,339	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	NONPAID WORKERS	0	0	0	0	0
193.02	19302	FOUNDATION	0	0	0	0	0
194.00	07950	PHYSICIANS CLINIC	22,821	2,779	0	2,779	0
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0
194.02	07952	FRESENIUS	49,271	6,000	0	0	0
194.03	07953	RUCHFORD POB	9,280	0	0	0	0
194.04	07954	EP COLEMAN RENTAL SPACE	54,798	6,673	0	0	0
194.05	07955	FARMINGTON POB	0	0	0	0	0
194.06	07956	LEWISTON POB	0	0	0	0	0
194.07	07957	OTHER RENTAL PROPERTY	3,447	0	0	0	0
194.08	07958	KELLEY HOME	0	0	0	0	0
194.09	07959	EMPLOYEE PURCHASE	50,650	0	0	0	0
194.10	07960	RETAIL PHARMACY	67,403	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	13,608,148	4,126,266	452,403	1,394,331	993,004
203.00		Unit cost multiplier (Wkst. B, Part I)	0.257369	15.311218	0.461248	7.668111	17.969020

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140001

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

Worksheet B-1

Date/Time Prepared:  
11/7/2016 9:02 am

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	1,871,829	491,422	53,490	89,560	152,145	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.035402	1.823506	0.054536	0.492534	2.753158	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140001

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

Worksheet B-1

Date/Time Prepared:  
11/7/2016 9:02 am

Cost Center Description		CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	27,709					11.00
13.00	01300	586	13,356				13.00
14.00	01400	201	0	2,985,217			14.00
15.00	01500	1,221	0	13,645	3,216,901		15.00
16.00	01600	2,208	0	0	0	37,748	16.00
20.00	02000	1,641	0	1,075	556	0	20.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	4,732	4,732	39,033	1,437	15,419	30.00
31.00	03100	903	903	8,565	242	1,687	31.00
43.00	04300	331	331	6,793	0	1,100	43.00
44.00	04400	1,679	1,679	11,156	90	786	44.00
45.00	04500	1,696	1,696	5,909	483	1,372	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	2,554	2,554	363,657	14,570	1,765	50.00
52.00	05200	148	0	0	0	0	52.00
53.00	05300	358	358	8,000	1,388	0	53.00
54.00	05400	1,444	0	6,003	8,366	7,099	54.00
57.00	05700	102	0	4,596	276	0	57.00
58.00	05800	100	0	116	0	0	58.00
60.00	06000	4,300	0	91,145	1,728	4,431	60.00
65.00	06500	714	0	12,842	2,369	0	65.00
66.00	06600	0	0	4,617	111	0	66.00
71.00	07100	0	0	727,790	0	0	71.00
72.00	07200	0	0	1,240,776	0	0	72.00
73.00	07300	0	0	0	2,329,973	0	73.00
76.97	07697	428	0	2,331	772	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	203,305	823,075	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
90.01	09001	12	12	146,166	7,660	0	90.01
91.00	09100	2,351	0	40,773	5,570	4,089	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	0	0	0	187	0	96.00
101.00	10100	0	881	10,812	78	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
116.00	11600	0	210	0	17,094	0	116.00
118.00		27,709	13,356	2,949,105	3,216,025	37,748	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	267	876	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	0	0	0	0	0	193.02
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	35,845	0	0	194.09
194.10	07960	0	0	0	0	0	194.10
200.00							200.00
201.00							201.00
202.00		753,557	831,310	239,034	1,204,002	1,248,119	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140001

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	27.195388	62.242438	0.080073	0.374274	33.064507	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	49,106	60,155	8,789	130,285	128,244	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.772204	4.503968	0.002944	0.040500	3.397372	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet B-1 Date/Time Prepared: 11/7/2016 9:02 am
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Cost Center Description		NURSING SCHOOL (ASSIGNED TIME)	
		20.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB	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
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
20.00	02000	NURSING SCHOOL	20.00
		610,830	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
45.00	04500	NURSING FACILITY	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
90.00	09000	CLINIC	90.00
90.01	09001	WOUND CLINIC	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	96.00
101.00	10100	HOME HEALTH AGENCY	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300	INTEREST EXPENSE	113.00
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
193.01	19301	NONPAID WORKERS	193.01
193.02	19302	FOUNDATION	193.02
194.00	07950	PHYSICIANS CLINIC	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	194.01
194.02	07952	FRESENIUS	194.02
194.03	07953	RUCHFORD POB	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	194.04
194.05	07955	FARMINGTON POB	194.05
194.06	07956	LEWISTON POB	194.06
194.07	07957	OTHER RENTAL PROPERTY	194.07
194.08	07958	KELLEY HOME	194.08
194.09	07959	EMPLOYEE PURCHASE	194.09
194.10	07960	RETAIL PHARMACY	194.10
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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140001

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

Worksheet B-1  
Date/Time Prepared:  
11/7/2016 9:02 am

Cost Center Description		NURSING SCHOOL (ASSIGNED TIME)	
		20.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	420,632	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.688624	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140001

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/7/2016 9:02 am

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
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	7,378,732		7,378,732	0	7,378,732 30.00	
31.00	03100 INTENSIVE CARE UNIT	1,443,435		1,443,435	0	1,443,435 31.00	
43.00	04300 NURSERY	559,428		559,428	0	559,428 43.00	
44.00	04400 SKILLED NURSING FACILITY	2,236,708		2,236,708	0	2,236,708 44.00	
45.00	04500 NURSING FACILITY	1,853,996		1,853,996	0	1,853,996 45.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	5,230,159		5,230,159	0	5,230,159 50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	223,038		223,038	0	223,038 52.00	
53.00	05300 ANESTHESIOLOGY	172,096		172,096	0	172,096 53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,088,414		3,088,414	0	3,088,414 54.00	
57.00	05700 CT SCAN	442,320		442,320	0	442,320 57.00	
58.00	05800 MRI	427,083		427,083	0	427,083 58.00	
60.00	06000 LABORATORY	5,489,719		5,489,719	0	5,489,719 60.00	
65.00	06500 RESPIRATORY THERAPY	925,879	0	925,879	0	925,879 65.00	
66.00	06600 PHYSICAL THERAPY	1,989,898	0	1,989,898	0	1,989,898 66.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	972,743		972,743	0	972,743 71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,659,465		1,659,465	0	1,659,465 72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	4,016,116		4,016,116	0	4,016,116 73.00	
76.97	07697 CARDIAC REHABILITATION	551,967		551,967	0	551,967 76.97	
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	16,906,629		16,906,629	0	16,906,629 88.00	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0 89.00	
90.00	09000 CLINIC	0		0	0	0 90.00	
90.01	09001 WOUND CLINIC	1,402,354		1,402,354	0	1,402,354 90.01	
91.00	09100 EMERGENCY	2,935,243		2,935,243	9,035	2,944,278 91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,019,408		1,019,408		1,019,408 92.00	
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	1,549,245		1,549,245	0	1,549,245 96.00	
101.00	10100 HOME HEALTH AGENCY	1,159,704		1,159,704		1,159,704 101.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						
116.00	11600 HOSPICE	323,791		323,791		323,791 116.00	
200.00	Subtotal (see instructions)	63,957,570	0	63,957,570	9,035	63,966,605 200.00	
201.00	Less Observation Beds	1,019,408		1,019,408		1,019,408 201.00	
202.00	Total (see instructions)	62,938,162	0	62,938,162	9,035	62,947,197 202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/7/2016 9:02 am
		Title XVII	Hospital	PPS

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					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	9,068,567		9,068,567	30.00
31.00	03100	INTENSIVE CARE UNIT	2,232,056		2,232,056	31.00
43.00	04300	NURSERY	288,831		288,831	43.00
44.00	04400	SKILLED NURSING FACILITY	1,549,563		1,549,563	44.00
45.00	04500	NURSING FACILITY	1,167,707		1,167,707	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	6,485,433	14,106,266	20,591,699	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	719,496	135,668	855,164	52.00
53.00	05300	ANESTHESIOLOGY	1,045,372	2,118,275	3,163,647	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,798,535	17,575,454	19,373,989	54.00
57.00	05700	CT SCAN	1,928,154	12,499,600	14,427,754	57.00
58.00	05800	MRI	191,355	5,292,996	5,484,351	58.00
60.00	06000	LABORATORY	6,191,683	23,125,889	29,317,572	60.00
65.00	06500	RESPIRATORY THERAPY	5,001,367	2,709,452	7,710,819	65.00
66.00	06600	PHYSICAL THERAPY	2,664,806	3,400,270	6,065,076	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,385,657	3,232,290	5,617,947	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,937,229	1,043,309	3,980,538	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,328,555	4,010,347	10,338,902	73.00
76.97	07697	CARDIAC REHABILITATION	204	635,118	635,322	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	26,776,914	26,776,914	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	WOUND CLINIC	15,376	3,997,396	4,012,772	90.01
91.00	09100	EMERGENCY	3,110,143	14,295,020	17,405,163	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	299,031	1,042,994	1,342,025	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	3,244,097	3,244,097	96.00
101.00	10100	HOME HEALTH AGENCY	0	643,752	643,752	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	334,343	334,343	116.00
200.00		Subtotal (see instructions)	55,409,120	140,219,450	195,628,570	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	55,409,120	140,219,450	195,628,570	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/7/2016 9:02 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
45.00	04500 NURSING FACILITY			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.253994		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.260813		52.00
53.00	05300 ANESTHESIOLOGY	0.054398		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.159410		54.00
57.00	05700 CT SCAN	0.030658		57.00
58.00	05800 MRI	0.077873		58.00
60.00	06000 LABORATORY	0.187250		60.00
65.00	06500 RESPIRATORY THERAPY	0.120075		65.00
66.00	06600 PHYSICAL THERAPY	0.328091		66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.173149		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.416895		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.388447		73.00
76.97	07697 CARDIAC REHABILITATION	0.868799		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 WOUND CLINIC	0.349473		90.01
91.00	09100 EMERGENCY	0.169161		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.759604		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.477558		96.00
101.00	10100 HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140001		Period: From 07/01/2015 To 06/30/2016		Worksheet D Part I Date/Time Prepared: 11/7/2016 9:02 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	617,556	0	617,556	7,564	81.64	30.00
31.00	INTENSIVE CARE UNIT	100,835		100,835	801	125.89	31.00
43.00	NURSERY	35,911		35,911	539	66.63	43.00
44.00	SKILLED NURSING FACILITY	190,681		190,681	3,605	52.89	44.00
45.00	NURSING FACILITY	179,042		179,042	6,302	28.41	45.00
200.00	Total (Lines 30-199)	1,124,025		1,124,025	18,811		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,164	258,309				
31.00	INTENSIVE CARE UNIT	474	59,672				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	2,378	125,772				
45.00	NURSING FACILITY	0	0				
200.00	Total (Lines 30-199)	6,016	443,753				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Prepared: 11/7/2016 9:02 am
		Title XVIII	Hospital	PPS

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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	810,591	20,591,699	0.039365	2,529,244	99,564	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	38,426	855,164	0.044934	3,541	159	52.00
53.00	05300 ANESTHESIOLOGY	36,967	3,163,647	0.011685	398,086	4,652	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	473,520	19,373,989	0.024441	903,615	22,085	54.00
57.00	05700 CT SCAN	102,679	14,427,754	0.007117	977,234	6,955	57.00
58.00	05800 MRI	105,907	5,484,351	0.019311	85,363	1,648	58.00
60.00	06000 LABORATORY	436,454	29,317,572	0.014887	2,565,535	38,193	60.00
65.00	06500 RESPIRATORY THERAPY	49,959	7,710,819	0.006479	1,399,598	9,068	65.00
66.00	06600 PHYSICAL THERAPY	121,633	6,065,076	0.020055	475,159	9,529	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	27,890	5,617,947	0.004964	2,025,846	10,056	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	47,577	3,980,538	0.011952	1,490,156	17,810	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	182,670	10,338,902	0.017668	2,775,462	49,037	73.00
76.97	07697 CARDIAC REHABILITATION	60,884	635,322	0.095832	194	19	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	1,071,863	26,776,914	0.040029	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	09001 WOUND CLINIC	70,483	4,012,772	0.017565	9,665	170	90.01
91.00	09100 EMERGENCY	266,959	17,405,163	0.015338	1,755,543	26,927	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	85,318	1,342,025	0.063574	153,874	9,782	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	75,980	3,244,097	0.023421	0	0	96.00
200.00	Total (lines 50-199)	4,065,760	180,343,751		17,548,115	305,654	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140001		Period: From 07/01/2015 To 06/30/2016		Worksheet D Part III Date/Time Prepared: 11/7/2016 9:02 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,196,179	0	0	0	1,196,179	30.00
31.00	03100	INTENSIVE CARE UNIT	136,399	0	0	0	136,399	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	182,713	0	0	0	182,713	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
200.00		Total (lines 30-199)	1,515,291	0	0	0	1,515,291	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,564	158.14	3,164	500,355		30.00
31.00	03100	INTENSIVE CARE UNIT	801	170.29	474	80,717		31.00
43.00	04300	NURSERY	539	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	3,605	50.68	2,378	120,517		44.00
45.00	04500	NURSING FACILITY	6,302	0.00	0	0		45.00
200.00		Total (lines 30-199)	18,811		6,016	701,589		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/7/2016 9:02 am
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Cost Center Description		Title XVIII				Hospital		PPS	
		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	261,904	0	0	261,904	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
57.00	05700	CT SCAN	0	0	0	0	0	57.00	
58.00	05800	MRI	0	0	0	0	0	58.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0	15,014	0	0	15,014	65.00	
66.00	06600	PHYSICAL THERAPY	0	7,700	0	0	7,700	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,700	0	0	7,700	73.00	
76.97	07697	CARDIAC REHABILITATION	0	48,700	0	0	48,700	76.97	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	62,560	0	0	62,560	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
90.00	09000	CLINIC	0	0	0	0	0	90.00	
90.01	09001	WOUND CLINIC	0	128,392	0	0	128,392	90.01	
91.00	09100	EMERGENCY	0	151,491	0	0	151,491	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	165,258	0	0	165,258	92.00	
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00	
200.00		Total (lines 50-199)	0	848,719	0	0	848,719	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/7/2016 9:02 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	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	261,904	20,591,699	0.012719	0.012719	2,529,244	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	855,164	0.000000	0.000000	3,541	52.00
53.00	05300 ANESTHESIOLOGY	0	3,163,647	0.000000	0.000000	398,086	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	19,373,989	0.000000	0.000000	903,615	54.00
57.00	05700 CT SCAN	0	14,427,754	0.000000	0.000000	977,234	57.00
58.00	05800 MRI	0	5,484,351	0.000000	0.000000	85,363	58.00
60.00	06000 LABORATORY	0	29,317,572	0.000000	0.000000	2,565,535	60.00
65.00	06500 RESPIRATORY THERAPY	15,014	7,710,819	0.001947	0.001947	1,399,598	65.00
66.00	06600 PHYSICAL THERAPY	7,700	6,065,076	0.001270	0.001270	475,159	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,617,947	0.000000	0.000000	2,025,846	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	3,980,538	0.000000	0.000000	1,490,156	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,700	10,338,902	0.000745	0.000745	2,775,462	73.00
76.97	07697 CARDIAC REHABILITATION	48,700	635,322	0.076654	0.076654	194	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	62,560	26,776,914	0.002336	0.002336	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001 WOUND CLINIC	128,392	4,012,772	0.031996	0.031996	9,665	90.01
91.00	09100 EMERGENCY	151,491	17,405,163	0.008704	0.008704	1,755,543	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	165,258	1,342,025	0.123141	0.123141	153,874	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	3,244,097	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	848,719	180,343,751			17,548,115	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/7/2016 9:02 am
Title XVIII		Hospital	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	32,169	3,744,973	47,632	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	444,577	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	5,067,360	0	54.00
57.00 05700 CT SCAN	0	4,082,681	0	57.00
58.00 05800 MRI	0	1,414,268	0	58.00
60.00 06000 LABORATORY	0	3,099,832	0	60.00
65.00 06500 RESPIRATORY THERAPY	2,725	893,166	1,739	65.00
66.00 06600 PHYSICAL THERAPY	603	15,771	20	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	590,137	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	583,092	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2,068	880,560	656	73.00
76.97 07697 CARDIAC REHABILITATION	15	343,869	26,359	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	90.00
90.01 09001 WOUND CLINIC	309	1,343,508	42,987	90.01
91.00 09100 EMERGENCY	15,280	3,510,822	30,558	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	18,948	395,861	48,747	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00 Total (lines 50-199)	72,117	26,410,477	198,698	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/7/2016 9:02 am
	Title XVIII	Hospital	PPS

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			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.253994	3,744,973	0	0	951,201	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.260813	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.054398	444,577	0	0	24,184	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159410	5,067,360	0	399	807,788	54.00
57.00	05700	CT SCAN	0.030658	4,082,681	0	0	125,167	57.00
58.00	05800	MRI	0.077873	1,414,268	0	73	110,133	58.00
60.00	06000	LABORATORY	0.187250	3,099,832	2,623	0	580,444	60.00
65.00	06500	RESPIRATORY THERAPY	0.120075	893,166	0	0	107,247	65.00
66.00	06600	PHYSICAL THERAPY	0.328091	15,771	0	0	5,174	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.173149	590,137	0	0	102,182	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.416895	583,092	0	0	243,088	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.388447	880,560	0	3,645	342,051	73.00
76.97	07697	CARDIAC REHABILITATION	0.868799	343,869	0	0	298,753	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.349473	1,343,508	0	406	469,520	90.01
91.00	09100	EMERGENCY	0.168642	3,510,822	0	0	592,072	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.759604	395,861	0	0	300,698	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.477558	0	0	0	0	96.00
200.00		Subtotal (see instructions)		26,410,477	2,623	4,523	5,059,702	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (Line 200 +/- Line 201)		26,410,477	2,623	4,523	5,059,702	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/7/2016 9:02 am
		Title XVIII	Hospital	PPS

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		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	64	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	6	58.00
60.00	06000 LABORATORY	491	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,416	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	0	0	90.00
90.01	09001 WOUND CLINIC	0	142	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00	Subtotal (see instructions)	491	1,628	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	491	1,628	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/7/2016 9:02 am
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	261,904	0	0	261,904	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	15,014	0	0	15,014	65.00
66.00	06600 PHYSICAL THERAPY	0	7,700	0	0	7,700	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7,700	0	0	7,700	73.00
76.97	07697 CARDIAC REHABILITATION	0	48,700	0	0	48,700	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	62,560	0	0	62,560	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 WOUND CLINIC	0	128,392	0	0	128,392	90.01
91.00	09100 EMERGENCY	0	151,491	0	0	151,491	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00	Total (lines 50-199)	0	683,461	0	0	683,461	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/7/2016 9:02 am
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	261,904	20,591,699	0.012719	0.012719	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	855,164	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	3,163,647	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	19,373,989	0.000000	0.000000	8,759	54.00
57.00	05700 CT SCAN	0	14,427,754	0.000000	0.000000	751	57.00
58.00	05800 MRI	0	5,484,351	0.000000	0.000000	0	58.00
60.00	06000 LABORATORY	0	29,317,572	0.000000	0.000000	15,959	60.00
65.00	06500 RESPIRATORY THERAPY	15,014	7,710,819	0.001947	0.001947	231,171	65.00
66.00	06600 PHYSICAL THERAPY	7,700	6,065,076	0.001270	0.001270	1,304,684	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,617,947	0.000000	0.000000	350,857	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	3,980,538	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,700	10,338,902	0.000745	0.000745	233,366	73.00
76.97	07697 CARDIAC REHABILITATION	48,700	635,322	0.076654	0.076654	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	62,560	26,776,914	0.002336	0.002336	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001 WOUND CLINIC	128,392	4,012,772	0.031996	0.031996	146	90.01
91.00	09100 EMERGENCY	151,491	17,405,163	0.008704	0.008704	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1,342,025	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	3,244,097	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	683,461	180,343,751			2,145,693	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140001	Period: From 07/01/2015	Worksheet D Part IV Date/Time Prepared: 11/7/2016 9:02 am
	Component CCN: 145572	To 06/30/2016	
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00 05700 CT SCAN	0	0	0	57.00
58.00 05800 MRI	0	0	0	58.00
60.00 06000 LABORATORY	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	450	0	0	65.00
66.00 06600 PHYSICAL THERAPY	1,657	0	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	174	0	0	73.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	90.00
90.01 09001 WOUND CLINIC	5	0	0	90.01
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00 Total (lines 50-199)	2,286	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/7/2016 9:02 am
	Title XVIII	Skilled Nursing Facility	PPS

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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.253994	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.260813	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.054398	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.159410	0	0	0	0	54.00
57.00 05700 CT SCAN	0.030658	0	0	0	0	57.00
58.00 05800 MRI	0.077873	0	0	0	0	58.00
60.00 06000 LABORATORY	0.187250	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.120075	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.328091	0	0	0	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.173149	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.416895	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.388447	0	225	913	0	73.00
76.97 07697 CARDIAC REHABILITATION	0.868799	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0.000000				0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
90.01 09001 WOUND CLINIC	0.349473	0	0	0	0	90.01
91.00 09100 EMERGENCY	0.168642	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.759604	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.477558	0	0	0	0	96.00
200.00	Subtotal (see instructions)		0	225	913	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	225	913	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/7/2016 9:02 am
	Title XVIII	Skilled Nursing Facility	PPS

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	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 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
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	87	355	73.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00 08800 RURAL HEALTH CLINIC	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00 09000 CLINIC	0	0	90.00
90.01 09001 WOUND CLINIC	0	0	90.01
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00 Subtotal (see instructions)	87	355	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 +/- line 201)	87	355	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/7/2016 9:02 am
		Title XVIII	Hospital	PPS
Cost Center Description		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,564	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,564	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)		6,519	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,164	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		7,378,732	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		7,378,732	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		7,378,732	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		975.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,086,514	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)		3,086,514	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/7/2016 9:02 am	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	1,443,435	801	1,802.04	474	854,167	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)					4,117,523	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,058,204	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)					899,053	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					377,771	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,276,824	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					6,781,380	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)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	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)					1,045	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					975.51	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,019,408	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140001		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/7/2016 9:02 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	617,556	7,378,732	0.083694	1,019,408	85,318	90.00
91.00	Nursing School cost	1,196,179	7,378,732	0.162112	1,019,408	165,258	91.00
92.00	Allied health cost	0	7,378,732	0.000000	1,019,408	0	92.00
93.00	All other Medical Education	0	7,378,732	0.000000	1,019,408	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1
		Component CCN: 145572		Date/Time Prepared: 11/7/2016 9:02 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,605	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,605	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,605	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,378	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,236,708	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,236,708	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,236,708	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140001 Component CCN: 145572		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/7/2016 9:02 am		
		Title XVIII		Skilled Nursing Facility		PPS		
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT						43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description							1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)							48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)							49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)							50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)							52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)							53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges							54.00
55.00	Target amount per discharge							55.00
56.00	Target amount (line 54 x line 55)							56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57.00
58.00	Bonus payment (see instructions)							58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61.00
62.00	Relief payment (see instructions)							62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)							63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)							64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)							65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)							66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						2,236,708	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						620.45	71.00
72.00	Program routine service cost (line 9 x line 71)						1,475,430	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						1,475,430	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)						0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						0	80.00
81.00	Inpatient routine service cost per diem limitation						0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)						1,475,430	83.00
84.00	Program inpatient ancillary services (see instructions)						611,672	84.00
85.00	Utilization review - physician compensation (see instructions)						0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						2,087,102	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140001 Component CCN: 145572		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/7/2016 9:02 am	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/7/2016 9:02 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		4,263,743	30.00
31.00	03100	INTENSIVE CARE UNIT		1,141,261	31.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.253994	2,529,244	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.260813	3,541	52.00
53.00	05300	ANESTHESIOLOGY	0.054398	398,086	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159410	903,615	54.00
57.00	05700	CT SCAN	0.030658	977,234	57.00
58.00	05800	MRI	0.077873	85,363	58.00
60.00	06000	LABORATORY	0.187250	2,565,535	60.00
65.00	06500	RESPIRATORY THERAPY	0.120075	1,399,598	65.00
66.00	06600	PHYSICAL THERAPY	0.328091	475,159	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.173149	2,025,846	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.416895	1,490,156	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.388447	2,775,462	73.00
76.97	07697	CARDIAC REHABILITATION	0.868799	194	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	WOUND CLINIC	0.349473	9,665	90.01
91.00	09100	EMERGENCY	0.169161	1,755,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.759604	153,874	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.477558	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		17,548,115	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)		17,548,115	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/7/2016 9:02 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.253994	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.260813	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.054398	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.159410	8,759	1,396	54.00
57.00	05700 CT SCAN	0.030658	751	23	57.00
58.00	05800 MRI	0.077873	0	0	58.00
60.00	06000 LABORATORY	0.187250	15,959	2,988	60.00
65.00	06500 RESPIRATORY THERAPY	0.120075	231,171	27,758	65.00
66.00	06600 PHYSICAL THERAPY	0.328091	1,304,684	428,055	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.173149	350,857	60,751	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.416895	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.388447	233,366	90,650	73.00
76.97	07697 CARDIAC REHABILITATION	0.868799	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 WOUND CLINIC	0.349473	146	51	90.01
91.00	09100 EMERGENCY	0.168642	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.759604	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.477558	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		2,145,693	611,672	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)		2,145,693		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/7/2016 9:02 am
		Title XVII I	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		1,322,064	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		4,345,436	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		32,799	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		40.14	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.01	30.00
31.00	Percentage of Medicaid patient days (see instructions)		20.93	31.00
32.00	Sum of lines 30 and 31		25.94	32.00
33.00	Allowable disproportionate share percentage (see instructions)		10.62	33.00
34.00	Disproportionate share adjustment (see instructions)		150,472	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/7/2016 9:02 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
<b>Uncompensated Care Adjustment</b>				
35.00	Total uncompensated care amount (see instructions)	7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000048212	0.000048482	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	368,708	310,583	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	92,935	232,513	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	325,448		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	6,176,219		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	7,142,306		48.00
				<b>Amount</b>
				<b>1.00</b>
49.00	Total payment for inpatient operating costs (see instructions)		7,142,306	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		452,433	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		490,601	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		581,072	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		72,117	58.00
59.00	Total (sum of amounts on lines 49 through 58)		8,738,529	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		8,738,529	61.00
62.00	Deductibles billed to program beneficiaries		866,432	62.00
63.00	Coinurance billed to program beneficiaries		0	63.00
64.00	Allowable bad debts (see instructions)		210,090	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		136,559	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		138,645	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		8,008,656	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-5,591	70.93
70.94	HRR adjustment amount (see instructions)		-60,109	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/7/2016 9:02 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2015	89,674	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2016	381,438	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		8,414,068	71.00
71.01	Sequestration adjustment (see instructions)		168,281	71.01
72.00	Interim payments		7,849,289	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		396,498	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
<b>HSP Bonus Payment Amount</b>				
100.00	HSP bonus amount (see instructions)		0	100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
<b>HRR Adjustment for HSP Bonus Payment</b>				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140001

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
11/7/2016 9:02 am

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,322,064	0	1,322,064		1,322,064	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,345,436	0		4,345,436	4,345,436	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	32,799	0	23,347	9,452	32,799	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1062	0.1062	0.1062	0.1062		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	150,472	0	35,101	115,371	150,472	11.00
11.01	Uncompensated care payments	36.00	325,448	0	92,935	232,513	405,963	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,176,219	0	1,473,447	4,702,772	6,176,219	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	7,142,306	0	1,667,174	5,475,132	7,142,306	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,142,306	0	1,667,174	5,475,132	7,142,306	15.00
16.00	Payment for inpatient program capital	50.00	452,433	0	107,285	345,148	452,433	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140001

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
11/7/2016 9:02 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	1,774,459	5,820,280	7,594,739	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	447,756	0	104,103	343,653	447,756	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	4,677	0	3,182	1,495	4,677	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	452,433	0	107,285	345,148	452,433	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.050536	0.065536		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			89,674		89,674	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				381,438	381,438	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5			Provider CCN: 140001		Period: From 07/01/2015 To 06/30/2016		Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/7/2016 9:02 am	
			Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)			
	0	1.00	2.00	3.00	4.00			
1.00	DRG amounts other than outlier payments	1.00						1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,322,064	1,322,064			1,322,064	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,345,436		4,345,436		4,345,436	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0			0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0		0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	32,799	23,348	9,452		32,800	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0		0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0		0	3.00
4.00	Managed care simulated payments	3.00	0	0	0		0	4.00
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000			5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0		0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0		0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000			7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0		0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0		0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0		0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0		0	9.01
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1062	0.1062	0.1062			10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	150,472	35,101	115,371		150,472	11.00
11.01	Uncompensated care payments	36.00	325,448	92,935	232,513		325,448	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0		0	12.00
13.00	Subtotal (see instructions)	47.00	6,176,219	1,473,448	4,702,771		6,176,219	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	7,142,306	0	0		0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,142,306	0	7,142,306		7,142,306	15.00
16.00	Payment for inpatient program capital	50.00	452,433	107,285	345,148		452,433	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0		0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0		0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0		0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0		0	18.00
19.00	<b>SUBTOTAL</b>			107,285	7,487,454		7,594,739	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/7/2016 9:02 am
		Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	447,756	104,103	343,653	447,756	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	4,677	3,182	1,495	4,677	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	452,433	107,285	345,148	452,433	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00		70.96	89,674	89,674		89,674	27.00
28.00	Low volume adjustment prior to October 1	70.96	89,674	89,674		89,674	28.00
29.00	Low volume adjustment on or after October 1	70.97	381,438		381,438	381,438	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-5,591	-3,481	-2,110	-5,591	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-60,109	-25,780	-34,329	-60,109	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/7/2016 9:02 am
		Title XVII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		2,119	1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)		4,861,004	2.00
3.00	PPS payments		4,441,327	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.862	5.00
6.00	Line 2 times line 5		4,190,185	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		198,698	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,119	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		7,146	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)		7,146	14.00
<b>Customary charges</b>				
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)		7,146	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		5,027	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)		2,119	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)		4,640,025	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		965,780	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		3,676,364	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		3,676,364	30.00
31.00	Primary payer payments		510	31.00
32.00	Subtotal (line 30 minus line 31)		3,675,854	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		248,356	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		161,431	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		180,195	36.00
37.00	Subtotal (see instructions)		3,837,285	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-86	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,837,371	40.00
40.01	Sequestration adjustment (see instructions)		76,747	40.01
41.00	Interim payments		3,599,269	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		161,355	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/7/2016 9:02 am
		Title XVII	Skilled Nursing Facility	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		442	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		442	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		1,138	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)		1,138	14.00
<b>Customary charges</b>				
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)		1,138	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		696	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)		442	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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		184	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		258	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)		258	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		258	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		258	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		258	40.00
40.01	Sequestration adjustment (see instructions)		5	40.01
41.00	Interim payments		163	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		90	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140001

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/7/2016 9:02 am

Title XVIII

Hospital

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		7,299,553		3,608,642	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	06/23/2016	549,736		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0	06/23/2016	9,373	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)		549,736		-9,373	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)		7,849,289		3,599,269	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		396,498		161,355	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		8,245,787		3,760,624	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: 140001  
Component CCN: 145572

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/7/2016 9:02 am  
PPS

Title XVIII  
Skilled Nursing Facility

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
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		874,909		163	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		874,909		163	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		132,297		90	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,007,206		253	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: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/7/2016 9:02 am
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		2,170	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		3,638	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		1,227	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		7,320	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		195,628,570	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		3,047,799	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)		372,014	8.00
9.00	Sequestration adjustment amount (see instructions)		7,440	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		364,574	10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)		356,030	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)		8,544	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part VI Date/Time Prepared: 11/7/2016 9:02 am
		Title XVIII	Skilled Nursing Facility	PPS
			1.00	
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		1,063,757	1.00
2.00	Routine service other pass through costs		120,517	2.00
3.00	Ancillary service other pass through costs		2,286	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,186,560	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		170,993	7.00
8.00	Allowable bad debts (see instructions)		18,760	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		12,194	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		1,027,761	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (see instructions)		1,027,761	15.00
15.01	Sequestration adjustment (see instructions)		20,555	15.01
16.00	Interim payments		874,909	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)		132,297	18.00
19.00	Protected amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet G Date/Time Prepared: 11/7/2016 9:02 am		
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	4,272,635	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	9,830,526	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,399,058	0	0	0	7.00
8.00	Prepaid expenses	1,473,321	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	16,975,540	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	5,083,867	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	64,352,966	0	0	0	15.00
16.00	Accumulated depreciation	-58,618,412	0	0	0	16.00
17.00	Leasehold improvements	9,320,052	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	28,724,946	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	11,345,790	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	60,209,209	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	65,790,622	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	11,368,622	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	77,159,244	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	154,343,993	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	5,186,810	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,493,980	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	905,000	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	543,847	0	0	0	43.00
44.00	Other current liabilities	350,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,479,637	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	31,173,515	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	10,001,551	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	41,175,066	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	51,654,703	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	102,689,290	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)	102,689,290	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	154,343,993	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140001

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

Worksheet G-1

Date/Time Prepared:  
11/7/2016 9:02 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		104,568,255		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-1,264,313				2.00
3.00	Total (sum of line 1 and line 2)		103,303,942		0		3.00
4.00	INCREASE IN TEMP RESTRICTED ASSETS	14,576		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		14,576		0		10.00
11.00	Subtotal (line 3 plus line 10)		103,318,518		0		11.00
12.00	CHANGE IN BENE INT PERPETUAL TRUST	629,228		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		629,228		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		102,689,290		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	INCREASE IN TEMP RESTRICTED ASSETS		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	CHANGE IN BENE INT PERPETUAL TRUST		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: 140001

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/7/2016 9:02 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
<b>General Inpatient Routine Services</b>					
1.00	Hospital	10,536,409		10,536,409	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,549,563		1,549,563	7.00
8.00	NURSING FACILITY	1,167,707		1,167,707	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	13,253,679		13,253,679	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>					
11.00	INTENSIVE CARE UNIT	2,242,216		2,242,216	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)	2,242,216		2,242,216	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	15,495,895		15,495,895	17.00
18.00	Ancillary services	38,039,265	92,760,971	130,800,236	18.00
19.00	Outpatient services	4,449,842	29,136,133	33,585,975	19.00
20.00	RURAL HEALTH CLINIC	0	26,776,914	26,776,914	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	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	0	334,343	334,343	26.00
27.00	NURSERY	299,067	0	299,067	27.00
27.01	GHA ACCRUED NET PATIENT REVENUE AT Y	0	50,332	50,332	27.01
27.02	OTHER SERVICES	2,662	359,735	362,397	27.02
27.03		0	0	0	27.03
27.04		0	0	0	27.04
27.05		0	0	0	27.05
27.06		0	0	0	27.06
27.07		0	0	0	27.07
27.08		0	0	0	27.08
27.09		0	0	0	27.09
27.10		0	0	0	27.10
27.11		0	0	0	27.11
27.12		0	0	0	27.12
27.13		0	0	0	27.13
27.14		0	0	0	27.14
27.15		0	0	0	27.15
27.16		0	0	0	27.16
27.17		0	0	0	27.17
27.18		0	0	0	27.18
27.19		0	0	0	27.19
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	58,286,731	149,418,428	207,705,159	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		78,001,083		29.00
30.00	LOSS ON REFINANCING OF DEBT	241,366			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)		241,366		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)		78,242,449		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140001

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

Worksheet G-3

Date/Time Prepared:  
11/7/2016 9:02 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	207,705,159	1.00
2.00	Less contractual allowances and discounts on patients' accounts	130,686,181	2.00
3.00	Net patient revenues (line 1 minus line 2)	77,018,978	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	78,242,449	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,223,471	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	117,143	6.00
7.00	Income from investments	2,330,471	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	NET ASSETS RELEASED FROM RESTRICTION	94,903	24.00
24.01	OTHER OPERATION REVENUE	3,373,701	24.01
24.02		0	24.02
24.03		0	24.03
24.05		0	24.05
24.06		0	24.06
25.00	Total other income (sum of lines 6-24)	5,916,218	25.00
26.00	Total (line 5 plus line 25)	4,692,747	26.00
27.00	PROVISION FOR UNCOLLECTIBLE ACCOUNTS	2,799,685	27.00
27.01	CHANGE IN UNREALIZED GAIN AND LOSS	1,571,864	27.01
27.02	CHANGE IN FV OF INTEREST RATE SWAP	1,585,511	27.02
27.03		0	27.03
27.04		0	27.04
27.05		0	27.05
28.00	Total other expenses (sum of line 27 and subscripts)	5,957,060	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,264,313	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140001

Period: From 07/01/2015

Worksheet H

HHA CCN: 147142

To 06/30/2016

Date/Time Prepared: 11/7/2016 9:02 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	194,739	0	0	0	63,816	258,555	5.00
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	234,435	0	7,121	0	5,269	246,825	6.00
7.00	Physical Therapy	0	0	0	0	69,324	69,324	7.00
8.00	Occupational Therapy	0	0	0	0	30,245	30,245	8.00
9.00	Speech Pathology	0	0	0	0	4,732	4,732	9.00
10.00	Medical Social Services	21,489	0	0	0	0	21,489	10.00
11.00	Home Health Aide	33,840	0	0	0	0	33,840	11.00
12.00	Supplies (see instructions)	0	0	0	0	12,898	12,898	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	484,503	0	7,121	0	186,284	677,908	24.00
		Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	4,806	263,361	-1,340	262,021			5.00
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	0	246,825	0	246,825			6.00
7.00	Physical Therapy	0	69,324	0	69,324			7.00
8.00	Occupational Therapy	0	30,245	0	30,245			8.00
9.00	Speech Pathology	0	4,732	0	4,732			9.00
10.00	Medical Social Services	0	21,489	0	21,489			10.00
11.00	Home Health Aide	0	33,840	0	33,840			11.00
12.00	Supplies (see instructions)	0	12,898	0	12,898			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	4,806	682,714	-1,340	681,374			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: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet H-1 Part I Date/Time Prepared: 11/7/2016 9:02 am
		HHA CCN: 147142	Home Health Agency I	PPS

	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				
	0	1.00	2.00	3.00	4.00	4A.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0		0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	262,021	0	0	0	262,021	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	246,825	0	0	0	246,825	6.00
7.00	Physical Therapy	69,324	0	0	0	69,324	7.00
8.00	Occupational Therapy	30,245	0	0	0	30,245	8.00
9.00	Speech Pathology	4,732	0	0	0	4,732	9.00
10.00	Medical Social Services	21,489	0	0	0	21,489	10.00
11.00	Home Health Aide	33,840	0	0	0	33,840	11.00
12.00	Supplies (see instructions)	12,898	0	0	0	12,898	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
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
24.00	Total (sum of lines 1-23)	681,374	0	0	0	681,374	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
<b>GENERAL SERVICE COST CENTERS</b>							
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	262,021					5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	154,221	401,046				6.00
7.00	Physical Therapy	43,315	112,639				7.00
8.00	Occupational Therapy	18,898	49,143				8.00
9.00	Speech Pathology	2,957	7,689				9.00
10.00	Medical Social Services	13,427	34,916				10.00
11.00	Home Health Aide	21,144	54,984				11.00
12.00	Supplies (see instructions)	8,059	20,957				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
24.00	Total (sum of lines 1-23)		681,374				24.00

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 140001 HHA CCN: 147142	Period: From 07/01/2015 To 06/30/2016	Worksheet H-1 Part II Date/Time Prepared: 11/7/2016 9:02 am PPS
			Home Health Agency I	

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-262,021	419,353
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	0	0	0	0	246,825
7.00	Physical Therapy	0	0	0	0	0	69,324
8.00	Occupational Therapy	0	0	0	0	0	30,245
9.00	Speech Pathology	0	0	0	0	0	4,732
10.00	Medical Social Services	0	0	0	0	0	21,489
11.00	Home Health Aide	0	0	0	0	0	33,840
12.00	Supplies (see instructions)	0	0	0	0	0	12,898
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-262,021	419,353
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		262,021
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.624822

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140001

Period: From 07/01/2015

Worksheet H-2

HHA CCN: 147142

To 06/30/2016

Part I  
Date/Time Prepared: 11/7/2016 9:02 am

Home Health Agency I

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Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	NEW CARDIAC REHAB	MVBLE EQUIP			
		1.00	1.01	2.00			
1.00 Administrative and General	0	0	0	12,870	102,621	115,491	1.00
2.00 Skilled Nursing Care	401,046	0	0	0	0	401,046	2.00
3.00 Physical Therapy	112,639	0	0	0	0	112,639	3.00
4.00 Occupational Therapy	49,143	0	0	0	0	49,143	4.00
5.00 Speech Pathology	7,689	0	0	0	0	7,689	5.00
6.00 Medical Social Services	34,916	0	0	0	0	34,916	6.00
7.00 Home Health Aide	54,984	0	0	0	0	54,984	7.00
8.00 Supplies (see instructions)	20,957	0	0	0	0	20,957	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	681,374	0	0	12,870	102,621	796,865	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	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
	5.00	7.00	8.00	9.00	10.00	11.00	
1.00 Administrative and General	29,724	0	0	0	0	0	1.00
2.00 Skilled Nursing Care	103,216	0	0	0	0	0	2.00
3.00 Physical Therapy	28,990	0	0	0	0	0	3.00
4.00 Occupational Therapy	12,648	0	0	0	0	0	4.00
5.00 Speech Pathology	1,979	0	0	0	0	0	5.00
6.00 Medical Social Services	8,986	0	0	0	0	0	6.00
7.00 Home Health Aide	14,151	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	5,394	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	205,088	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

(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: 140001

Period: From 07/01/2015

Worksheet H-2

HHA CCN: 147142

To 06/30/2016

Part I  
Date/Time Prepared: 11/7/2016 9:02 am

Home Health Agency I

PPS

Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal	
		13.00	14.00	15.00	16.00	20.00	24.00	
1.00	Administrative and General	0	0	0	0	102,020	247,235	1.00
2.00	Skilled Nursing Care	54,836	0	0	0	0	559,098	2.00
3.00	Physical Therapy	0	0	0	0	0	141,629	3.00
4.00	Occupational Therapy	0	0	0	0	0	61,791	4.00
5.00	Speech Pathology	0	0	0	0	0	9,668	5.00
6.00	Medical Social Services	0	0	0	0	0	43,902	6.00
7.00	Home Health Aide	0	0	0	0	0	69,135	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	26,351	8.00
9.00	Drugs	0	866	29	0	0	895	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	54,836	866	29	0	102,020	1,159,704	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		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	247,235					1.00
2.00	Skilled Nursing Care	0	559,098	151,488	710,586			2.00
3.00	Physical Therapy	0	141,629	38,375	180,004			3.00
4.00	Occupational Therapy	0	61,791	16,742	78,533			4.00
5.00	Speech Pathology	0	9,668	2,620	12,288			5.00
6.00	Medical Social Services	0	43,902	11,895	55,797			6.00
7.00	Home Health Aide	0	69,135	18,732	87,867			7.00
8.00	Supplies (see instructions)	0	26,351	7,140	33,491			8.00
9.00	Drugs	0	895	243	1,138			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19) (2)	0	1,159,704	247,235	1,159,704			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.			0.270952				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: 140001 HHA CCN: 147142	Period: From 07/01/2015 To 06/30/2016	Worksheet H-2 Part II Date/Time Prepared: 11/7/2016 9:02 am
			Home Health Agency I	PPS

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	1.01	2.00				
1.00 Administrative and General	0	0	12,798	484,504	0	115,491	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	401,046	2.00
3.00 Physical Therapy	0	0	0	0	0	112,639	3.00
4.00 Occupational Therapy	0	0	0	0	0	49,143	4.00
5.00 Speech Pathology	0	0	0	0	0	7,689	5.00
6.00 Medical Social Services	0	0	0	0	0	34,916	6.00
7.00 Home Health Aide	0	0	0	0	0	54,984	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	20,957	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	12,798	484,504	0	796,865	20.00
21.00 Total cost to be allocated	0	0	12,870	102,621	0	205,088	21.00
22.00 Unit cost multiplier	0.000000	0.000000	1.005626	0.211806	0	0.257369	22.00
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	0	0	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	881	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	0	0	0	881	20.00
21.00 Total cost to be allocated	0	0	0	0	0	54,836	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	62.242906	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 140001 HHA CCN: 147142	Period: From 07/01/2015 To 06/30/2016	Worksheet H-2 Part II Date/Time Prepared: 11/7/2016 9:02 am
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Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)		
	14.00	15.00	16.00	20.00		
1.00 Administrative and General	0	0	0	26,500		1.00
2.00 Skilled Nursing Care	0	0	0	0		2.00
3.00 Physical Therapy	0	0	0	0		3.00
4.00 Occupational Therapy	0	0	0	0		4.00
5.00 Speech Pathology	0	0	0	0		5.00
6.00 Medical Social Services	0	0	0	0		6.00
7.00 Home Health Aide	0	0	0	0		7.00
8.00 Supplies (see instructions)	0	0	0	0		8.00
9.00 Drugs	10,812	78	0	0		9.00
10.00 DME	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0		13.00
14.00 Clinic	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0		19.00
20.00 Total (sum of lines 1-19)	10,812	78	0	26,500		20.00
21.00 Total cost to be allocated	866	29	0	102,020		21.00
22.00 Unit cost multiplier	0.080096	0.371795	0.000000	3.849811		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS					Provider CCN: 140001 HHA CCN: 147142	Period: From 07/01/2015 To 06/30/2016	Worksheet H-3 Part I Date/Time Prepared: 11/7/2016 9:02 am	
					Title XVII I	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 (col. 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	710,586		710,586	1,491	476.58	1.00
2.00	Physical Therapy	3.00	180,004	0	180,004	661	272.32	2.00
3.00	Occupational Therapy	4.00	78,533	0	78,533	285	275.55	3.00
4.00	Speech Pathology	5.00	12,288	0	12,288	52	236.31	4.00
5.00	Medical Social Services	6.00	55,797		55,797	21	2,657.00	5.00
6.00	Home Health Aide	7.00	87,867		87,867	672	130.75	6.00
7.00	Total (sum of lines 1-6)		1,125,075	0	1,125,075	3,182		7.00
Program Visits								
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Part B			
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care		99914	0	723			8.00
8.01	Skilled Nursing Care		37900	0	0			8.01
9.00	Physical Therapy		99914	0	356			9.00
9.01	Physical Therapy		37900	0	5			9.01
10.00	Occupational Therapy		99914	0	179			10.00
10.01	Occupational Therapy		37900	0	0			10.01
11.00	Speech Pathology		99914	0	30			11.00
11.01	Speech Pathology		37900	0	0			11.01
12.00	Medical Social Services		99914	0	12			12.00
12.01	Medical Social Services		37900	0	0			12.01
13.00	Home Health Aide		99914	0	346			13.00
13.01	Home Health Aide		37900	0	0			13.01
14.00	Total (sum of lines 8-13)			0	1,651			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 (col. 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	33,491	0	33,491	15,733	2.128710	15.00
16.00	Cost of Drugs	9.00	1,138	0	1,138	0	0.000000	16.00
Program Visits								
Cost Center Description		Part A	Part B		Cost of Services			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
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	723		0	344,567		1.00
2.00	Physical Therapy	0	361		0	98,308		2.00
3.00	Occupational Therapy	0	179		0	49,323		3.00
4.00	Speech Pathology	0	30		0	7,089		4.00
5.00	Medical Social Services	0	12		0	31,884		5.00
6.00	Home Health Aide	0	346		0	45,240		6.00
7.00	Total (sum of lines 1-6)	0	1,651		0	576,411		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 140001	Period: From 07/01/2015	Worksheet H-3
				HHA CCN: 147142	To 06/30/2016	Part I
				Title XVII I	Home Health Agency I	Date/Time Prepared: 11/7/2016 9:02 am
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Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

Cost Center Description		Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance
		6.00	7.00	8.00	9.00	10.00	11.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	15,733	0	0	33,491	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	344,567						1.00
2.00	Physical Therapy	98,308						2.00
3.00	Occupational Therapy	49,323						3.00
4.00	Speech Pathology	7,089						4.00
5.00	Medical Social Services	31,884						5.00
6.00	Home Health Aide	45,240						6.00
7.00	Total (sum of lines 1-6)	576,411						7.00
Cost Center Description								
		12.00						

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

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 140001 HHA CCN: 147142	Period: From 07/01/2015 To 06/30/2016	Worksheet H-3 Part II Date/Time Prepared: 11/7/2016 9:02 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	
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>						
1.00 Physical Therapy	66.00	0.328091	0	0	col. 2, line 2.00	1.00
2.00 Occupational Therapy						2.00
3.00 Speech Pathology						3.00
4.00 Cost of Medical Supplies	71.00	0.173149	0	0	col. 2, line 15.00	4.00
5.00 Cost of Drugs	73.00	0.388447	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 140001 HHA CCN: 147142	Period: From 07/01/2015 To 06/30/2016	Worksheet H-4 Part I-II Date/Time Prepared: 11/7/2016 9:02 am
		Title XVII I	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
<b>PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES</b>				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	272,150	145,406	0
<b>Customary Charges</b>				
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)	272,150	145,406	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	272,150	145,406	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
<b>PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT</b>				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	251,152
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	3,388
13.00	Total PPS Reimbursement - LUPA Episodes		0	8,061
14.00	Total PPS Reimbursement - PEP Episodes		0	1,174
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	97
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	263,872
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	263,872
25.00	Coinurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	263,872
27.00	Reimbursable bad debts (from your records)			0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	263,872
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	263,872
31.01	Sequestration adjustment (see instructions)		0	5,278
32.00	Interim payments (see instructions)		0	258,594
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 PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet H-5
	HHA CCN: 147142	Home Health Agency I	Date/Time Prepared: 11/7/2016 9:02 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		258,594	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		258,594	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		258,594	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS		Provider CCN: 140001 Hospice CCN: 141558		Period: From 07/01/2015 To 06/30/2016		Worksheet K Date/Time Prepared: 11/7/2016 9:02 am	
		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	129,462	0	0	7,647	32,279	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	129,462	0	0	7,647	32,279	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140001

Period: From 07/01/2015

Worksheet K

Hospice CCN: 141558

To 06/30/2016

Date/Time Prepared: 11/7/2016 9:02 am

		Hospice I					
		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	169,388	4,806	174,194	0	174,194	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	169,388	4,806	174,194	0	174,194	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140001

Period: From 07/01/2015

Worksheet K-1

Hospice CCN: 141558

To 06/30/2016

Date/Time Prepared: 11/7/2016 9:02 am

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	84,058	0	0	0	17,995	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	84,058	0	0	0	17,995	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140001

Period: From 07/01/2015

Worksheet K-1

Hospice CCN: 141558

To 06/30/2016

Date/Time Prepared: 11/7/2016 9:02 am

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
<b>VISITING SERVICES</b>						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	27,409	129,462	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	0	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	27,409	129,462	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES		Provider CCN: 140001	Period: From 07/01/2015	Worksheet K-3
		Hospice CCN: 141558	To 06/30/2016	Date/Time Prepared: 11/7/2016 9:02 am

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES		Provider CCN: 140001 Hospice CCN: 141558		Period: From 07/01/2015 To 06/30/2016		Worksheet K-3 Date/Time Prepared: 11/7/2016 9:02 am	
		Aides		All-Other		Hospice I	
		Total Therapists			Total (1)		
		6.00	7.00	8.00	9.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	7,647	7,647		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	7,647	7,647		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140001  
Hospice CCN: 141558

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

Worksheet K-4  
Part I  
Date/Time Prepared:  
11/7/2016 9:02 am

		Hospice I					
		CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION		
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES				MOVABLE EQUIPMENT
		0	1.00	2.00	3.00	4.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	174,194	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	174,194	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140001

Period: From 07/01/2015

Worksheet K-4

Hospice CCN: 141558

To 06/30/2016

Part I  
Date/Time Prepared:  
11/7/2016 9:02 am

		Hospice I				
		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col . 5A ± col . 6)	
		5.00	5A	6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance					3.00
4.00	Transportation - Staff					4.00
5.00	Volunteer Service Coordination	0				5.00
6.00	Administrative and General	0	0	0		6.00
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
<b>VISITING SERVICES</b>						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	0	174,194	0	174,194	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	174,194		174,194	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140001  
Hospice CCN: 141558

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

Worksheet K-4  
Part II  
Date/Time Prepared:  
11/7/2016 9:02 am

		CAPITAL RELATED COST		PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT (\$ VALUE)				
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	0	0	0			3.00
4.00	Transportation - Staff	0	0	0	0		4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0	0	0	0	39.00
40.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	40.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140001

Period: From 07/01/2015

Worksheet K-4

Hospice CCN: 141558

To 06/30/2016

Part II  
Date/Time Prepared:  
11/7/2016 9:02 am

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	
		6A	6.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	0	174,194	6.00
<b>INPATIENT CARE SERVICE</b>				
7.00	Inpatient - General Care	0	0	7.00
8.00	Inpatient - Respite Care	0	0	8.00
<b>VISITING SERVICES</b>				
9.00	Physician Services	0	0	9.00
10.00	Nursing Care	0	174,194	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	0	12.00
13.00	Occupational Therapy	0	0	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	0	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		0	39.00
40.00	Unit Cost Multiplier		0.000000	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001

Period: From 07/01/2015

Worksheet K-5

Hospice CCN: 141558

To 06/30/2016

Part I  
Date/Time Prepared:  
11/7/2016 9:02 am

Hospice I

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	NEW CARDIAC REHAB	MVBLE EQUIP		
		1.00	1.01	2.00		
1.00 Administrative and General		0	0	0	27,421	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	174,194	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	174,194	0	0	0	27,421	34.00
35.00 Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001

Period:

Worksheet K-5

Hospice CCN: 141558

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

Part I  
Date/Time Prepared:  
11/7/2016 9:02 am

Cost Center Description		Subtotal	Hospice I				
			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
1.00	Administrative and General	27,421	7,057	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	174,194	44,832	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	201,615	51,889	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)	0					35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001

Period: From 07/01/2015

Worksheet K-5

Hospice CCN: 141558

To 06/30/2016

Part I  
Date/Time Prepared:  
11/7/2016 9:02 am

Cost Center Description	Hospice I					
	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
1.00 Administrative and General	0	0	0	0	0	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	13,071	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	6,398	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	0	13,071	0	6,398	34.00
35.00 Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		Provider CCN: 140001	Period: From 07/01/2015	Worksheet K-5
		Hospice CCN: 141558	To 06/30/2016	Part I Date/Time Prepared: 11/7/2016 9:02 am

Cost Center Description	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal (col s. 4A-23)	Hospice I Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (col s. 24 ± 25)	
	16.00	20.00	24.00	25.00	26.00	
1.00 Administrative and General	0	50,818	85,296			1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	232,097	0	232,097	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	6,398	0	6,398	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specif y	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	50,818	323,791	0	323,791	34.00
35.00 Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		Provider CCN: 140001	Period: From 07/01/2015	Worksheet K-5 Part I
		Hospice CCN: 141558	To 06/30/2016	Date/Time Prepared: 11/7/2016 9:02 am
			Hospice I	

Cost Center Description		Allocated Hospice A&G (See Part 11)	Total Hospice Costs (col s. 26 ± 27)	
		27.00	28.00	
1.00	Administrative and General			1.00
2.00	Inpatient - General Care	0	0	2.00
3.00	Inpatient - Respite Care	0	0	3.00
4.00	Physician Services	0	0	4.00
5.00	Nursing Care	83,008	315,105	5.00
6.00	Nursing Care-Continuous Home Care	0	0	6.00
7.00	Physical Therapy	0	0	7.00
8.00	Occupational Therapy	0	0	8.00
9.00	Speech/ Language Pathology	0	0	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Spiritual Counseling	0	0	11.00
12.00	Dietary Counseling	0	0	12.00
13.00	Counseling - Other	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	15.00
16.00	Other	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	2,288	8,686	17.00
18.00	Analgesics	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	19.00
20.00	Other - Specify	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	21.00
22.00	Patient Transportation	0	0	22.00
23.00	Imaging Services	0	0	23.00
24.00	Labs and Diagnostics	0	0	24.00
25.00	Medical Supplies	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	26.00
27.00	Radiation Therapy	0	0	27.00
28.00	Chemotherapy	0	0	28.00
29.00	Other	0	0	29.00
30.00	Bereavement Program Costs	0	0	30.00
31.00	Volunteer Program Costs	0	0	31.00
32.00	Fundraising	0	0	32.00
33.00	Other Program Costs	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)		323,791	34.00
35.00	Unit Cost Multiplier (see instructions)	0.357643		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 140001

Period:

Worksheet K-5

Hospice CCN: 141558

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

Part II  
Date/Time Prepared:  
11/7/2016 9:02 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	Reconciliation	
	BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
	1.00	1.01	2.00			
				4.00	5A	
1.00 Administrative and General	0	0	0	129,462	0	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	0	0	129,462		34.00
35.00 Total cost to be allocated	0	0	0	27,421		35.00
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.211807		36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 140001  
Hospice CCN: 141558

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

Worksheet K-5  
Part II  
Date/Time Prepared:  
11/7/2016 9:02 am

Cost Center Description	Hospice I					DIETARY (MEALS SERVED)	
	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)			
	5.00	7.00	8.00	9.00	10.00		
1.00 Administrative and General	27,421	0	0	0	0	0	1.00
2.00 Inpatient - General Care	0	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	0	4.00
5.00 Nursing Care	174,194	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	201,615	0	0	0	0	0	34.00
35.00 Total cost to be allocated	51,889	0	0	0	0	0	35.00
36.00 Unit Cost Multiplier (see instructions)	0.257367	0.000000	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 140001  
Hospice CCN: 141558

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

Worksheet K-5  
Part II  
Date/Time Prepared:  
11/7/2016 9:02 am

Cost Center Description		Hospice I					
		CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	210	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	17,094	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	210	0	17,094	0	34.00
35.00	Total cost to be allocated	0	13,071	0	6,398	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	62.242857	0.000000	0.374283	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS STATISTICAL BASIS	Provider CCN: 140001 Hospice CCN: 141558	Period: From 07/01/2015 To 06/30/2016	Worksheet K-5 Part II Date/Time Prepared: 11/7/2016 9:02 am
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Cost Center Description		NURSING SCHOOL (ASSIGNED TIME) 20.00	Hospice I	
1.00	Administrative and General	13,200		1.00
2.00	Inpatient - General Care	0		2.00
3.00	Inpatient - Respite Care	0		3.00
4.00	Physician Services	0		4.00
5.00	Nursing Care	0		5.00
6.00	Nursing Care-Continuous Home Care	0		6.00
7.00	Physical Therapy	0		7.00
8.00	Occupational Therapy	0		8.00
9.00	Speech/ Language Pathology	0		9.00
10.00	Medical Social Services	0		10.00
11.00	Spiritual Counseling	0		11.00
12.00	Dietary Counseling	0		12.00
13.00	Counseling - Other	0		13.00
14.00	Home Health Aide and Homemaker	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0		15.00
16.00	Other	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0		17.00
18.00	Analgesics	0		18.00
19.00	Sedatives / Hypnotics	0		19.00
20.00	Other - Specify	0		20.00
21.00	Durable Medical Equipment/Oxygen	0		21.00
22.00	Patient Transportation	0		22.00
23.00	Imaging Services	0		23.00
24.00	Labs and Diagnostics	0		24.00
25.00	Medical Supplies	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0		26.00
27.00	Radiation Therapy	0		27.00
28.00	Chemotherapy	0		28.00
29.00	Other	0		29.00
30.00	Bereavement Program Costs	0		30.00
31.00	Volunteer Program Costs	0		31.00
32.00	Fundraising	0		32.00
33.00	Other Program Costs	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	13,200		34.00
35.00	Total cost to be allocated	50,818		35.00
36.00	Unit Cost Multiplier (see instructions)	3.849848		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 140001 Hospice CCN: 141558	Period: From 07/01/2015 To 06/30/2016	Worksheet K-5 Part III Date/Time Prepared: 11/7/2016 9:02 am		
Cost Center Description		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2) 3.00	
		0	1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.328091	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00				2.00
3.00	SPEECH PATHOLOGY	68.00				3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.388447	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0.477558	0	0	5.00
6.00	LABORATORY	60.00	0.187250	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.173149	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00				10.00
10.97	CARDIAC REHABILITATION	76.97	0.868799	0	0	10.97
11.00	Totals (sum of lines 1-10)					11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 140001  
 Hospice CCN: 141558

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

Worksheet K-6  
 Date/Time Prepared:  
 11/7/2016 9:02 am

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				323,791	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				1,987	2.00
3.00	Average cost per diem (line 1 divided by line 2)				162.95	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	1,884				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	306,998				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		32			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		5,214			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			71		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			11,569		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet L Parts I-III Date/Time Prepared: 11/7/2016 9:02 am
		Title XVII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		447,756	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		4,677	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		20.28	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		452,433	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140001 Component CCN: 143493	Period: From 07/01/2015 To 06/30/2016	Worksheet M-1 Date/Time Prepared: 11/7/2016 9:02 am
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassified	Reclassified Trial Balance (col. 3 + col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1.00	Physician	199,736	0	199,736	0	199,736	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	2,208,261	0	2,208,261	-123,350	2,084,911	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	1,191,603	0	1,191,603	-45,134	1,146,469	9.00
10.00	Subtotal (sum of lines 1 through 9)	3,599,600	0	3,599,600	-168,484	3,431,116	10.00
11.00	Physician Services Under Agreement	0	9,078,879	9,078,879	-1,601,654	7,477,225	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	9,078,879	9,078,879	-1,601,654	7,477,225	14.00
15.00	Medical Supplies	0	231,732	231,732	0	231,732	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	0	0	0	0	18.00
19.00	Other Health Care Costs	0	30,268	30,268	0	30,268	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	262,000	262,000	0	262,000	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,599,600	9,340,879	12,940,479	-1,770,138	11,170,341	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
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	0	0	0	0	28.00
<b>FACILITY OVERHEAD</b>							
29.00	Facility Costs	0	10,772	10,772	0	10,772	29.00
30.00	Administrative Costs	26,284	74,182	100,466	0	100,466	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	26,284	84,954	111,238	0	111,238	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,625,884	9,425,833	13,051,717	-1,770,138	11,281,579	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140001	Period: From 07/01/2015 To 06/30/2016	Worksheet M-1
	Component CCN: 143493		Date/Time Prepared: 11/7/2016 9:02 am
		Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>			
1.00 Physician	0	199,736	1.00
2.00 Physician Assistant	0	0	2.00
3.00 Nurse Practitioner	0	0	3.00
4.00 Visiting Nurse	0	0	4.00
5.00 Other Nurse	0	2,084,911	5.00
6.00 Clinical Psychologist	0	0	6.00
7.00 Clinical Social Worker	0	0	7.00
8.00 Laboratory Technician	0	0	8.00
9.00 Other Facility Health Care Staff Costs	0	1,146,469	9.00
10.00 Subtotal (sum of lines 1 through 9)	0	3,431,116	10.00
11.00 Physician Services Under Agreement	0	7,477,225	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	7,477,225	14.00
15.00 Medical Supplies	0	231,732	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	0	18.00
19.00 Other Health Care Costs	0	30,268	19.00
20.00 Allowable GME Costs	0	0	20.00
21.00 Subtotal (sum of lines 15 through 20)	0	262,000	21.00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	11,170,341	22.00
<b>COSTS OTHER THAN RHC/FOHC SERVICES</b>			
23.00 Pharmacy	0	0	23.00
24.00 Dental	0	0	24.00
25.00 Optometry	0	0	25.00
26.00 All other nonreimbursable costs	0	0	26.00
27.00 Nonallowable GME costs	0	0	27.00
28.00 Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
<b>FACILITY OVERHEAD</b>			
29.00 Facility Costs	-4,442	6,330	29.00
30.00 Administrative Costs	-2,843	97,623	30.00
31.00 Total Facility Overhead (sum of lines 29 and 30)	-7,285	103,953	31.00
32.00 Total facility costs (sum of lines 22, 28 and 31)	-7,285	11,274,294	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 140001 Component CCN: 143493	Period: From 07/01/2015 To 06/30/2016	Worksheet M-2 Date/Time Prepared: 11/7/2016 9:02 am
			Rural Health Clinic (RHC) I	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>VISITS AND PRODUCTIVITY</b>						
<b>Positions</b>						
1.00	Physician	19.05	75,042	4,200	80,010	1.00
2.00	Physician Assistant	2.94	10,012	2,100	6,174	2.00
3.00	Nurse Practitioner	3.75	10,193	2,100	7,875	3.00
4.00	Subtotal (sum of lines 1 through 3)	25.74	95,247		94,059	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FOHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FOHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	25.74	95,247			8.00
9.00	Physician Services Under Agreements		0			9.00
					1.00	

<b>DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES</b>				
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)		11,170,341	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)		11,170,341	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)		1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)		103,953	14.00
15.00	Parent provider overhead allocated to facility (see instructions)		5,632,335	15.00
16.00	Total overhead (sum of lines 14 and 15)		5,736,288	16.00
17.00	Allowable GME overhead (see instructions)		0	17.00
18.00	Subtotal (see instructions)		5,736,288	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)		5,736,288	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		16,906,629	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140001 Component CCN: 143493	Period: From 07/01/2015 To 06/30/2016	Worksheet M-3 Date/Time Prepared: 11/7/2016 9:02 am
		Title XVIIII	Rural Health Clinic (RHC) I	Cost
				1.00
<b>DETERMINATION OF RATE FOR RHC/FQHC SERVICES</b>				
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		16,906,629	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		263,140	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		16,643,489	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		95,247	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)		95,247	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		174.74	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions)	174.74	174.74	9.00
<b>CALCULATION OF SETTLEMENT</b>				
10.00	Program covered visits excluding mental health services (from contractor records)	5,005	13,870	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	874,574	2,423,644	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		3,298,218	16.00
16.01	Total program charges (see instructions)(from contractor's records)		2,990,240	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		70,812	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		78,105	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.)		2,395,324	16.04
16.05	Total program cost (see instructions)		2,473,429	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		225,958	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		525,440	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		2,473,429	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		81,261	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		2,554,690	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		2,554,690	26.00
26.01	Sequestration adjustment (see instructions)		51,094	26.01
27.00	Interim payments		2,213,640	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		289,956	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 140001 Component CCN: 143493	Period: From 07/01/2015 To 06/30/2016	Worksheet M-4 Date/Time Prepared: 11/7/2016 9:02 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3,431,116	3,431,116	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.008868	0.009275	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	30,427	31,824	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	98,985	12,624	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	129,412	44,448	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	11,170,341	11,170,341	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	5,736,288	5,736,288	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.011585	0.003979	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	66,455	22,825	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	195,867	67,273	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	2,458	2,571	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	79.69	26.17	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	757	800	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	60,325	20,936	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)		263,140	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)		81,261	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140001 Component CCN: 143493	Period: From 07/01/2015 To 06/30/2016	Worksheet M-5 Date/Time Prepared: 11/7/2016 9:02 am
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		2,272,841	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50		06/23/2016	59,201	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)		-59,201	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		2,213,640	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		289,956	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		2,503,596	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00