

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/18/2016 1:54 pm
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 11/18/2016 Time: 1:54 pm	
	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.		
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 SARAH BUSH LINCOLN HEALTH CENTER ( 140189 ) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-162,444	162,129	0	0	1.00
2.00 Subprovider - IPF	0	55,813	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
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-CASEY I	0		1,852		0	10.00
10.01 RURAL HEALTH CLINIC II-SULLIVAN	0		1,409		0	10.01
10.02 RURAL HEALTH CLINIC III-NEOGA	0		2,304		0	10.02
10.03 RURAL HEALTH CLINIC IV-NEWTON	0		149		0	10.03
10.04 RURAL HEALTH CLINIC V-MARTINSVILLE	0		0		0	10.04
200.00 Total	0	-106,631	167,843	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 140189		Period: From 07/01/2015 To 06/30/2016		Worksheet S-2 Part I Date/Time Prepared: 11/18/2016 1:05 pm			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00 Street: 1000 HEALTH CENTER DRIVE		PO Box: 372		Zip Code: 61920-		County: COLES					
2.00 City: MATTOON		State: IL									
		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		SARAH BUSH LINCOLN HEALTH CENTER		140189	99914	1	05/01/1977	N	P	O	3.00
4.00 Subprovider - IPF		SARAH BUSH LINCOLN HEALTH CENTER		14S189	99914	4	01/01/1990	N	P	O	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											9.00
10.00 Hospital-Based NF											10.00
11.00 Hospital-Based OLTC											11.00
12.00 Hospital-Based HHA		LINCOLN LAND HOME CARE OF SBLHS		147594	99914		06/18/1996	N	P	N	12.00
13.00 Separately Certified ASC											13.00
14.00 Hospital-Based Hospice		LINCOLN LAND HOSPICE OF SBLHS		141599	99914		08/10/1999				14.00
15.00 Hospital-Based Health Clinic - RHC		CASEY RHC		143978	99914		06/15/1992	N	O	N	15.00
15.01 Hospital-Based Health Clinic - RHC		SULLIVAN RHC		143998	99914		01/13/1995	N	O	N	15.01
15.02 Hospital-Based Health Clinic - RHC		NEOGA RHC		143435	99914		05/31/1997	N	O	N	15.02
15.03 Hospital-Based Health Clinic - RHC		NEWTON RHC		148541	99914		07/01/2014	N	O	N	15.03
15.04 Hospital-Based Health Clinic - RHC		MARTINSVILLE RHC		148555	99914		07/01/2015	N	O	N	15.04
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.								1	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140189			Period: From 07/01/2015 To 06/30/2016		Worksheet S-2 Part I Date/Time Prepared: 11/18/2016 1:05 pm		
		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.	4,326	0	0	0	0	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00	
						Urban/Rural	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					1		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.					07/01/2015	06/30/2016	36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					N		37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	N	40.00	
						V	XVII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.								58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)					N			60.00

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
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
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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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		
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				
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010		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.				Y				70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0		71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N				75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						0		76.00

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				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.			N	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.	Y	N	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
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)			N	106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.			N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N	108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				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.	1			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	5,341,398	0	0	118.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/18/2016 1:05 pm		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02		
DO NOT USE THIS LINE						
119.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	119.00		
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			120.00		
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00		
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00		
<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		125.00		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00		
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00		
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00		
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00		
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00		
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00		
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00		
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00		
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00		
<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		140.00		
		1.00	2.00	3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00		
142.00	Street:	PO Box:		142.00		
143.00	City:	State:	Zip Code:	143.00		
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?			Y		
		1.00	2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00		
				1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		
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		
		Part A	Part B	Title V		
		1.00	2.00	3.00		
				Title XIX		
				4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140189		Period: From 07/01/2015 To 06/30/2016		Worksheet S-2 Part I Date/Time Prepared: 11/18/2016 1:05 pm		
							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.						N	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)						0.00	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)				07/01/2015	06/30/2016	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. 1, 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: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/18/2016 1:05 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	09/30/2016	Y	09/30/2016
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/18/2016 1:05 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
<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			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<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.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			Y	35.00
			Y/N	Date	
			1.00	2.00	
<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.	BARB		IPPOLITO	41.00
42.00	Enter the employer/company name of the cost report preparer.	SARAH BUSH LINCOLN HEALTH CENTER			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-258-2509		BI PPOLIT0@SBLHS.ORG	43.00

		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.	REIMB. ACCOUNTANT	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: 140189

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/18/2016 1:05 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	76	27,816	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)		76	27,816	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT	32.00	9	3,294	0.00	0	9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		85	31,110	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	20	7,320		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY	45.00	0	0		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 RURAL HEALTH CLINIC-CASEY	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II-SULLIVAN	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III-NEOGA	88.02				0	26.02
26.03 RURAL HEALTH CLINIC IV-NEWTON	88.03				0	26.03
26.04 RURAL HEALTH CLINIC V-MARTINSVILLE	88.04				0	26.04
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		105				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: 140189

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/18/2016 1:05 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	10,355	2,920	19,660			1.00
2.00 HMO and other (see instructions)	2,523	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	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)	10,355	2,920	19,660			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT	1,188	404	2,318			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		723	1,348			13.00
14.00 Total (see instructions)	11,543	4,047	23,326	0.00	1,745.07	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,085	1,382	3,146	0.00	25.71	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY		0	0	0.00	0.00	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	20,342	0	31,377	0.00	57.66	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	29.05	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC-CASEY	623	0	2,655	0.00	4.79	26.00
26.01 RURAL HEALTH CLINIC II-SULLIVAN	833	0	3,805	0.00	6.06	26.01
26.02 RURAL HEALTH CLINIC III-NEOGA	1,685	0	6,584	0.00	7.51	26.02
26.03 RURAL HEALTH CLINIC IV-NEWTON	1,254	0	6,315	0.00	7.69	26.03
26.04 RURAL HEALTH CLINIC V-MARTINSVILLE	0	0	8,707	0.00	8.53	26.04
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	1,892.07	27.00
28.00 Observation Bed Days		1,266	5,310			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	279	553			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: 140189

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/18/2016 1:05 pm

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	2,877	1,338	6,483	1.00
2.00	HMO and other (see instructions)			544	36		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	2,877	1,338	6,483	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	176	363	704	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						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	RURAL HEALTH CLINIC-CASEY	0.00					26.00
26.01	RURAL HEALTH CLINIC II-SULLIVAN	0.00					26.01
26.02	RURAL HEALTH CLINIC III-NEOGA	0.00					26.02
26.03	RURAL HEALTH CLINIC IV-NEWTON	0.00					26.03
26.04	RURAL HEALTH CLINIC V-MARTINSVILLE	0.00					26.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140189		Period: From 07/01/2015 To 06/30/2016		Worksheet S-3 Part II Date/Time Prepared: 11/18/2016 1:05 pm	
	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	132,655,655	0	132,655,655	3,917,757.00	33.86	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		1,737,238	0	1,737,238	17,832.00	97.42	3.00
4.00	Physician-Part A - Administrative		266,686	0	266,686	1,103.00	241.78	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		18,387,552	0	18,387,552	81,585.00	225.38	5.00
6.00	Non-physician-Part B		771,791	0	771,791	11,631.00	66.36	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	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		42,926,010	0	42,926,010	994,736.00	43.15	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	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)		33,104,829	0	33,104,829			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		8,377,560	0	8,377,560			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		471,970	0	471,970			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		51,648	0	51,648			22.01
23.00	Physician Part B		2,320,478	0	2,320,478			23.00
24.00	Wage-related costs (RHC/FQHC)		149,861	0	149,861			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	743,363	0	743,363	23,030.00	32.28	26.00
27.00	Administrative & General	5.00	12,686,065	0	12,686,065	423,021.00	29.99	27.00
28.00	Administrative & General under contract (see inst.)		420,343	0	420,343	1,533.00	274.20	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,195,044	0	1,195,044	53,414.00	22.37	30.00
31.00	Laundry & Linen Service	8.00	27,360	0	27,360	3,662.00	7.47	31.00
32.00	Housekeeping	9.00	1,511,973	0	1,511,973	104,482.00	14.47	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,469,958	-1,025,590	444,368	29,294.00	15.17	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,025,590	1,025,590	67,609.00	15.17	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,271,453	0	2,271,453	73,529.00	30.89	38.00
39.00	Central Services and Supply	14.00	643,079	0	643,079	31,127.00	20.66	39.00
40.00	Pharmacy	15.00	1,580,272	0	1,580,272	43,975.00	35.94	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140189

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
11/18/2016 1:05 pm

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on 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	
41.00	Medi cal Records & Medi cal Records Li brary	16.00	1,483,237	0	1,483,237	128,275.00	11.56	41.00
42.00	Soci al Servi ce	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Servi ce	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140189

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
11/18/2016 1:05 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on 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 III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	112,179,417	0	112,179,417	3,808,242.00	29.46	1.00
2.00	Excluded area salaries (see instructions)	42,926,010	0	42,926,010	994,736.00	43.15	2.00
3.00	Subtotal salaries (line 1 minus line 2)	69,253,407	0	69,253,407	2,813,506.00	24.61	3.00
4.00	Subtotal other wages & related costs (see inst.)	0	0	0	0.00	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)	33,104,829	0	33,104,829	0.00	47.80	5.00
6.00	Total (sum of lines 3 thru 5)	102,358,236	0	102,358,236	2,813,506.00	36.38	6.00
7.00	Total overhead cost (see instructions)	24,032,147	0	24,032,147	982,951.00	24.45	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet S-3 Part IV Date/Time Prepared: 11/18/2016 1:05 pm
				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		5,334,637	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		424,885	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		16,381,904	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		755,308	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		308,167	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		34,168	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		347,714	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		1,847,026	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		7,424,403	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		57,309	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		0	22.00
23.00	Tuition Reimbursement		189,308	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		33,104,829	24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet S-3 Part V Date/Time Prepared: 11/18/2016 1:05 pm
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		0	0 1.00
2.00	Hospital		0	0 2.00
3.00	Subprovider - IPF		0	0 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			8.00
9.00	Hospital-Based NF		0	0 9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA		0	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
14.01	Hospital-Based Health Clinic RHC 1		0	0 14.01
14.02	Hospital-Based Health Clinic RHC 2		0	0 14.02
14.03	Hospital-Based Health Clinic RHC 3		0	0 14.03
14.04	Hospital-Based Health Clinic RHC 4		0	0 14.04
15.00	Hospital-Based Health Clinic FQHC			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: 140189 Component CCN: 147594		Period: From 07/01/2015 To 06/30/2016		Worksheet S-4 Date/Time Prepared: 11/18/2016 1:05 pm PPS	
				Home Health Agency I			
				1.00			
0.00	County			COLES		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	0.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
				0	1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		0.62	0.00	0.62	3.00
4.00	Director(s) and Assistant Director(s)			2.04	0.00	2.04	4.00
5.00	Other Administrative Personnel			13.02	0.00	13.02	5.00
6.00	Direct Nursing Service			27.64	0.00	27.64	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			6.59	0.00	6.59	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			2.79	0.00	2.79	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.62	0.00	0.62	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.81	0.00	0.81	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			3.54	0.00	3.54	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			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
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	10,191	1,359	348	310	12,208	21.00
22.00	Skilled Nursing Visit Charges	1,828,159	236,807	66,471	55,479	2,186,916	22.00
23.00	Physical Therapy Visits	3,588	119	56	108	3,871	23.00
24.00	Physical Therapy Visit Charges	668,327	21,658	10,558	20,022	720,565	24.00
25.00	Occupational Therapy Visits	1,376	81	17	34	1,508	25.00
26.00	Occupational Therapy Visit Charges	252,445	14,803	3,155	6,249	276,652	26.00
27.00	Speech Pathology Visits	148	4	3	9	164	27.00
28.00	Speech Pathology Visit Charges	27,241	728	607	1,699	30,275	28.00
29.00	Medical Social Service Visits	180	14	3	6	203	29.00
30.00	Medical Social Service Visit Charges	40,140	3,122	669	1,338	45,269	30.00
31.00	Home Health Aide Visits	1,926	413	9	40	2,388	31.00
32.00	Home Health Aide Visit Charges	150,228	32,214	702	3,120	186,264	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	17,409	1,990	436	507	20,342	33.00
34.00	Other Charges	124,870	20,615	9,435	3,083	158,003	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	3,091,410	329,947	91,597	90,990	3,603,944	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,326		46	0	1,372	36.00
37.00	Total Number of Outlier Episodes		49		1	50	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143978	Period: From 07/01/2015 To 06/30/2016	Worksheet S-8 Date/Time Prepared: 11/18/2016 1:05 pm Cost	
		Rural Health Clinic (RHC) I		1.00	
1.00	Clinic Address and Identification Street		412 NW 3RD		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		CASEY	IL62420	2.00
				1.00	
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0 3.00
		Grant Award	Date		
		1.00	2.00		
4.00		Source of Federal Funds			
5.00		Community Health Center (Section 330(d), PHS Act)		0	4.00
6.00		Migrant Health Center (Section 329(d), PHS Act)		0	5.00
7.00		Health Services for the Homeless (Section 340(d), PHS Act)		0	6.00
8.00		Appalachian Regional Commission		0	7.00
9.00		Look-Alikes		0	8.00
9.00		OTHER (SPECIFY)		0	9.00
				1.00	2.00
10.00	Does this facility operate as other than an RHC or FOHC? 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	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
				5.00	
11.00	Facility hours of operations (1) Clinic		08:00	17:00	08:00
				1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?		N		0 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.				0 13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	Provider name, CCN number				
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
				Total Visits	
				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)				
		County		4.00	
2.00	City, State, ZIP Code, County		CLARK		2.00
		Tuesday		Wednesday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		Thursday		to	
				10.00	
11.00	Facility hours of operations (1) Clinic		17:00	08:00	17:00
				08:00	17:00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 140189 Component CCN: 143978	Period: From 07/01/2015 To 06/30/2016	Worksheet S-8 Date/Time Prepared: 11/18/2016 1:05 pm Cost
		Rural Health Clinic (RHC) I	

	Friday		Saturday			
	from	to	from	to		
	11.00	11.00	12.00	13.00		
11.00	Facility hours of operations (1) Clinic		08:00	17:00		11.00



HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2015 To 06/30/2016	Worksheet S-8 Date/Time Prepared: 11/18/2016 1:05 pm Cost	
		Rural Health Clinic (RHC) II			
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
11.00	Facility hours of operations (1) Clinic	08:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143435	Period: From 07/01/2015 To 06/30/2016	Worksheet S-8 Date/Time Prepared: 11/18/2016 1:05 pm Cost	
		Rural Health Clinic (RHC) III			
		1.00			
1.00	Clinic Address and Identification Street		650 OAK AVENUE		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		NEOGA	IL	62447
		1.00			
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0
		Grant Award		Date	
		1.00		2.00	
4.00		Source of Federal Funds			
5.00		Community Health Center (Section 330(d), PHS Act)		0	4.00
6.00		Migrant Health Center (Section 329(d), PHS Act)		0	5.00
7.00		Health Services for the Homeless (Section 340(d), PHS Act)		0	6.00
8.00		Appalachian Regional Commission		0	7.00
9.00		Look-Alikes		0	8.00
9.00		OTHER (SPECIFY)		0	9.00
		1.00		2.00	
10.00	Does this facility operate as other than an RHC or FOHC? 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
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		5.00	
11.00	Facility hours of operations (1) Clinic		08:00	17:00	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?		N		0
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.				0
		Provider name		CCN number	
		1.00		2.00	
14.00	Provider name, CCN number				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
				Total Visits	
				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		CUMBERLAND		2.00
		Tuesday		Wednesday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		Thursday		to	
		6.00		10.00	
11.00	Facility hours of operations (1) Clinic		17:00	08:00	17:00
		08:00		08:00	
		17:00		17:00	
		08:00		17:00	
		17:00		17:00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143435	Period: From 07/01/2015 To 06/30/2016	Worksheet S-8 Date/Time Prepared: 11/18/2016 1:05 pm	
			Rural Health Clinic (RHC) III	Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
11.00	Facility hours of operations (1) Clinic	08:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 148541	Period: From 07/01/2015 To 06/30/2016	Worksheet S-8 Date/Time Prepared: 11/18/2016 1:05 pm Cost	
		Rural Health Clinic (RHC) IV		1.00	
1.00	Clinic Address and Identification Street		910 SOUTH VAN BUREN ST		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		NEWTON	IL	62448
				1.00	
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0
		Grant Award		Date	
		1.00		2.00	
4.00		Source of Federal Funds			
5.00		Community Health Center (Section 330(d), PHS Act)		0	
6.00		Migrant Health Center (Section 329(d), PHS Act)		0	
7.00		Health Services for the Homeless (Section 340(d), PHS Act)		0	
8.00		Appalachian Regional Commission		0	
9.00		Look-Alikes		0	
9.00		OTHER (SPECIFY)		0	
				1.00	
10.00	Does this facility operate as other than an RHC or FOHC? 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
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
				5.00	
11.00	Facility hours of operations (1) Clinic		08:00	17:00	08:00
				1.00	
				2.00	
12.00	Have you received an approval for an exception to the productivity standard?		N		0
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.				0
		Provider name		CCN number	
		1.00		2.00	
14.00	Provider name, CCN number		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)				
		County		4.00	
2.00	City, State, ZIP Code, County		JASPER		2.00
		Tuesday		Wednesday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		Thursday		to	
				10.00	
11.00	Facility hours of operations (1) Clinic		17:00	08:00	17:00
				08:00	
				17:00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 148541	Period: From 07/01/2015 To 06/30/2016	Worksheet S-8 Date/Time Prepared: 11/18/2016 1:05 pm		
			Rural Health Clinic (RHC) IV	Cost		
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
11.00	Facility hours of operations (1) Clinic	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 148555	Period: From 07/01/2015 To 06/30/2016	Worksheet S-8 Date/Time Prepared: 11/18/2016 1:05 pm Cost	
		Rural Health Clinic (RHC) V		1.00	
1.00	Clinic Address and Identification Street		890 E RIDGELAWN RD		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		MARTINSVILLE IL 62442		2.00
				1.00	
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0 3.00
		Grant Award	Date		
		1.00	2.00		
4.00		Source of Federal Funds			
5.00		Community Health Center (Section 330(d), PHS Act)		0	4.00
6.00		Migrant Health Center (Section 329(d), PHS Act)		0	5.00
7.00		Health Services for the Homeless (Section 340(d), PHS Act)		0	6.00
8.00		Appalachian Regional Commission		0	7.00
9.00		Look-Alikes		0	8.00
9.00		OTHER (SPECIFY)		0	9.00
				1.00	2.00
10.00	Does this facility operate as other than an RHC or FOHC? 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	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
				5.00	
11.00	Facility hours of operations (1) Clinic		08:00	17:00	08:00 11.00
				1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?		N		0 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.				0 13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	Provider name, CCN number				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
				Total Visits	
				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		CLARK		2.00
		Tuesday		Wednesday	
		to	from	to	from
		6.00	7.00	8.00	9.00
				Thursday	
				to	
				10.00	
11.00	Facility hours of operations (1) Clinic		17:00	08:00	17:00 08:00 17:00 11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 148555	Period: From 07/01/2015 To 06/30/2016	Worksheet S-8 Date/Time Prepared: 11/18/2016 1:05 pm Cost	
		Rural Health Clinic (RHC) V			
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
11.00	Facility hours of operations (1) Clinic	08:00	17:00		11.00

HOSPITAL IDENTIFICATION DATA

Provider CCN: 140189  
Component CCN: 141599

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

Worksheet S-9  
Parts I & II  
Date/Time Prepared:  
11/18/2016 1:05 pm

		Hospice I						
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of col.s. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART I - ENROLLMENT DAYS</b>								
1.00	Continuous Home Care	0	0	0	0	0	0	
2.00	Routine Home Care	17,444	1,753	9,768	655	1,528	20,725	
3.00	Inpatient Respite Care	50	15	50	15	9	74	
4.00	General Inpatient Care	74	7	74	7	4	85	
5.00	Total Hospice Days	17,568	1,775	9,892	677	1,541	20,884	
<b>Part II - CENSUS DATA</b>								
6.00	Number of Patients Receiving Hospice Care	540	39	337	22	41	620	
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				
8.00	Average Length of Stay (line 5/line 6)	32.53	45.51	29.35	30.77	37.59	33.68	
9.00	Unduplicated Census Count	480	35	302	20	35	550	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet S-10 Date/Time Prepared: 11/18/2016 1:05 pm
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			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)		0.258086	1.00	
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		14,943,135	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		8,306,283	5.00	
6.00	Medicaid charges		129,894,990	6.00	
7.00	Medicaid cost (line 1 times line 6)		33,524,078	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)		10,274,660	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)		10,274,660	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	2,701,002	11,431,699	14,132,701	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	697,091	2,950,361	3,647,452	21.00
22.00	Partial payment by patients approved for charity care	77,924	2,050,310	2,128,234	22.00
23.00	Cost of charity care (line 21 minus line 22)	619,167	900,051	1,519,218	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)		7,939,150	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		1,056,910	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		6,882,240	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,776,210	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		3,295,428	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		13,570,088	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140189

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

Worksheet A  
Date/Time Prepared:  
11/18/2016 1:05 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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	CAP REL COSTS-BLDG & FIXT	0	0	7,420,795	7,420,795	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	9,485,552	9,485,552	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	743,363	26,250,868	26,994,231	27,224,961	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,686,065	38,438,852	51,124,917	32,750,860	5.00
7.00	00700	OPERATION OF PLANT	1,195,044	3,391,492	4,586,536	4,555,228	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,360	619,418	646,778	646,778	8.00
9.00	00900	HOUSEKEEPING	1,511,973	438,649	1,950,622	1,950,622	9.00
10.00	01000	DIETARY	1,469,958	1,490,091	2,960,049	894,573	10.00
11.00	01100	CAFETERIA	0	0	2,065,226	2,065,226	11.00
13.00	01300	NURSING ADMINISTRATION	2,271,453	333,356	2,604,809	2,595,736	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	643,079	900,072	1,543,151	1,502,160	14.00
15.00	01500	PHARMACY	1,580,272	13,024,619	14,604,891	1,903,687	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,483,237	1,060,571	2,543,808	2,535,651	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	16,346,858	2,810,843	19,157,701	17,947,171	30.00
32.00	03200	CORONARY CARE UNIT	1,795,880	1,057,799	2,853,679	2,852,398	32.00
40.00	04000	SUBPROVIDER - I/PF	3,011,510	255,415	3,266,925	3,286,652	40.00
43.00	04300	NURSERY	0	26,379	26,379	543,116	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	5,131,264	2,598,618	7,729,882	7,694,387	50.00
51.00	05100	RECOVERY ROOM	1,315,861	299,030	1,614,891	1,605,971	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	90,639	90,639	874,820	52.00
53.00	05300	ANESTHESIOLOGY	5,707,537	1,258,280	6,965,817	7,431,016	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,809,474	1,328,452	8,137,926	7,830,809	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,142,932	401,717	2,544,649	2,571,649	55.00
56.00	05600	RADIOISOTOPE	1,093,982	1,320,067	2,414,049	2,613,954	56.00
57.00	05700	CT SCAN	416,541	717,141	1,133,682	1,205,695	57.00
58.00	05800	MRI	336,585	510,974	847,559	911,021	58.00
59.00	05900	CARDIAC CATHETERIZATION	526,924	495,074	1,021,998	1,012,572	59.00
60.00	06000	LABORATORY	5,048,203	5,303,720	10,351,923	10,387,630	60.00
65.00	06500	RESPIRATORY THERAPY	1,047,424	461,385	1,508,809	1,505,869	65.00
66.00	06600	PHYSICAL THERAPY	1,875,977	931,901	2,807,878	2,787,315	66.00
67.00	06700	OCCUPATIONAL THERAPY	490,275	60,751	551,026	551,026	67.00
68.00	06800	SPEECH PATHOLOGY	826,626	518,721	1,345,347	1,344,537	68.00
69.00	06900	ELECTROCARDIOLOGY	1,383,398	2,773,597	4,156,995	4,157,051	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,112,945	1,212,751	2,325,696	2,344,823	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,948,531	3,948,531	3,948,531	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,670,927	5,670,927	5,670,927	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,528,761	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	565,095	58,337	623,432	600,343	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC-CASEY	275,977	113,354	389,331	398,166	88.00
88.01	08801	RURAL HEALTH CLINIC II-SULLIVAN	397,097	132,633	529,730	551,554	88.01
88.02	08802	RURAL HEALTH CLINIC III-NEOGA	674,494	116,105	790,599	812,561	88.02
88.03	08803	RURAL HEALTH CLINIC IV-NEWTON	442,191	161,042	603,233	622,639	88.03
88.04	08805	RURAL HEALTH CLINIC V-MARTINSVILLE	833,505	209,097	1,042,602	1,034,900	88.04
91.00	09100	EMERGENCY	9,520,796	2,128,749	11,649,545	11,885,388	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	3,552,456	823,469	4,375,925	4,365,930	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	HOSPICE	1,539,271	1,114,504	2,653,775	2,457,013	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	97,832,882	124,857,990	222,690,872	221,868,024	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	30,964,078	8,289,039	39,253,117	40,306,744	192.00
194.00	07950	WELLNESS	723,830	545,966	1,269,796	1,262,063	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	1,198,516	1,703,692	2,902,208	2,898,877	194.01
194.02	07951	LIFELINE	20,066	116,468	136,534	136,534	194.02
194.03	07952	OCCUPATIONAL HEALTH	494,661	218,584	713,245	496,248	194.03
194.05	07954	MISC. NONREIMBURSABLE	1,421,622	530,969	1,952,591	1,949,873	194.05
200.00		TOTAL (SUM OF LINES 118-199)	132,655,655	136,262,708	268,918,363	268,918,363	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140189

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

Worksheet A  
Date/Time Prepared:  
11/18/2016 1:05 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,633,863	5,786,932	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	9,485,552	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-312,282	26,912,679	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,231,288	27,519,572	5.00
7.00	00700	OPERATION OF PLANT	-332	4,554,896	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	646,778	8.00
9.00	00900	HOUSEKEEPING	-462	1,950,160	9.00
10.00	01000	DIETARY	-650	893,923	10.00
11.00	01100	CAFETERIA	-959,171	1,106,055	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,595,736	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,502,160	14.00
15.00	01500	PHARMACY	0	1,903,687	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-119,521	2,416,130	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-3,779,553	14,167,618	30.00
32.00	03200	CORONARY CARE UNIT	0	2,852,398	32.00
40.00	04000	SUBPROVIDER - I/PF	-1,728,721	1,557,931	40.00
43.00	04300	NURSERY	0	543,116	43.00
45.00	04500	NURSING FACILITY	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	7,694,387	50.00
51.00	05100	RECOVERY ROOM	0	1,605,971	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	874,820	52.00
53.00	05300	ANESTHESIOLOGY	-5,884,445	1,546,571	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,401,132	3,429,677	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-1,227,590	1,344,059	55.00
56.00	05600	RADIOISOTOPE	0	2,613,954	56.00
57.00	05700	CT SCAN	0	1,205,695	57.00
58.00	05800	MRI	0	911,021	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,012,572	59.00
60.00	06000	LABORATORY	-789,071	9,598,559	60.00
65.00	06500	RESPIRATORY THERAPY	-149,072	1,356,797	65.00
66.00	06600	PHYSICAL THERAPY	-5,675	2,781,640	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	551,026	67.00
68.00	06800	SPEECH PATHOLOGY	-971,241	373,296	68.00
69.00	06900	ELECTROCARDIOLOGY	-2,649,735	1,507,316	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-639,530	1,705,293	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,948,531	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,670,927	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,528,761	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	600,343	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC-CASEY	0	398,166	88.00
88.01	08801	RURAL HEALTH CLINIC II-SULLIVAN	0	551,554	88.01
88.02	08802	RURAL HEALTH CLINIC III-NEOGA	0	812,561	88.02
88.03	08803	RURAL HEALTH CLINIC IV-NEWTON	0	622,639	88.03
88.04	08805	RURAL HEALTH CLINIC V-MARTINSVILLE	0	1,034,900	88.04
91.00	09100	EMERGENCY	-6,501,023	5,384,365	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	HOME HEALTH AGENCY	0	4,365,930	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
116.00	11600	HOSPICE	0	2,457,013	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-36,984,357	184,883,667	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	40,306,744	192.00
194.00	07950	WELLNESS	0	1,262,063	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	2,898,877	194.01
194.02	07951	LIFELINE	0	136,534	194.02
194.03	07952	OCCUPATIONAL HEALTH	0	496,248	194.03
194.05	07954	MISC. NONREIMBURSABLE	0	1,949,873	194.05
200.00		TOTAL (SUM OF LINES 118-199)	-36,984,357	231,934,006	200.00

RECLASSIFICATIONS

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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - DRUGS CHARGED TO PATIENTS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	12,528,761	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		0	12,528,761	
<b>B - RADIOLOGY ADMIN EXPENSE ALLOCATION</b>					
1.00	RADIOISOTOPE	56.00	175,248	24,657	1.00
2.00	CT SCAN	57.00	66,727	13,395	2.00
3.00	MRI	58.00	53,918	9,544	3.00
	0		295,893	47,596	
<b>C - CAP REL COSTS-MOVABLE EQUIP</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	737,138	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
	0		0	737,138	
<b>D - DEPRECIATION</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,590,163	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,748,414	2.00
	0		0	14,338,577	
<b>E - CAFETERIA EXPENSE</b>					
1.00	CAFETERIA	11.00	1,025,590	1,039,636	1.00
	0		1,025,590	1,039,636	
<b>F - EMPLOYEE PHYSICALS/BENEF EXP</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	214,813	1.00
	0		0	214,813	
<b>G - EAP BENEFITS</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	22,587	1.00
	0		0	22,587	
<b>H - INTEREST EXPENSE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,830,632	1.00
	0		0	1,830,632	
<b>I - NURSERY/L&amp;D EXP</b>					
1.00	NURSERY	43.00	516,737	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	784,181	0	2.00
	0		1,300,918	0	
<b>J - PHYSN PROF LIAB EXP</b>					
1.00	ADULTS & PEDIATRICS	30.00	0	116,434	1.00
2.00	SUBPROVIDER - IPF	40.00	0	23,718	2.00
3.00	ANESTHESIOLOGY	53.00	0	468,972	3.00
4.00	RADIOLOGY-THERAPEUTIC	55.00	0	29,109	4.00
5.00	LABORATORY	60.00	0	12,937	5.00

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		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
6.00	ELECTROCARDIOLOGY	69.00	0	6,469		6.00
7.00	EMERGENCY	91.00	0	242,572		7.00
8.00	RURAL HEALTH CLINIC-CASEY	88.00	0	9,703		8.00
9.00	RURAL HEALTH CLINIC II-SULLIVAN	88.01	0	22,640		9.00
10.00	RURAL HEALTH CLINIC III-NEOGA	88.02	0	22,640		10.00
11.00	RURAL HEALTH CLINIC IV-NEWTON	88.03	0	19,406		11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,098,850		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	38,811		13.00
14.00	ELECTROENCEPHALOGRAPHY	70.00	0	25,874		14.00
15.00	RURAL HEALTH CLINIC V-MARTINSVILLE	88.04	0	20,183		15.00
	0		0	2,158,318		
	K - RHC V-LAB STAFF EXPENSE					
1.00	LABORATORY	60.00	23,871	1,826		1.00
	TOTALS		23,871	1,826		
500.00	Grand Total: Increases		2,646,272	32,919,884		500.00

RECLASSIFICATIONS

Provider CCN: 140189

Period:  
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To 06/30/2016

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Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
<b>A - DRUGS CHARGED TO PATIENTS</b>						
1.00 PHARMACY	15.00	0	12,508,870	0	1.00	
2.00 RECOVERY ROOM	51.00	0	8,009	0	2.00	
3.00 ANESTHESIOLOGY	53.00	0	3,773	0	3.00	
4.00 CT_SCAN	57.00	0	8,109	0	4.00	
0		0	12,528,761			
<b>B - RADIOLOGY ADMIN EXPENSE ALLOCATION</b>						
1.00 RADIOLOGY-DIAGNOSTIC	54.00	295,893	47,596	0	1.00	
2.00	0.00	0	0	0	2.00	
3.00	0.00	0	0	0	3.00	
0		295,893	47,596			
<b>C - CAP REL COSTS-MOVABLE EQUIP</b>						
1.00 EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,670	14	1.00	
2.00 ADMINISTRATIVE & GENERAL	5.00	0	46,530	14	2.00	
3.00 OPERATION OF PLANT	7.00	0	31,308	14	3.00	
4.00 NURSING ADMINISTRATION	13.00	0	9,073	14	4.00	
5.00 CENTRAL SERVICES & SUPPLY	14.00	0	40,991	14	5.00	
6.00 PHARMACY	15.00	0	192,334	14	6.00	
7.00 MEDICAL RECORDS & LIBRARY	16.00	0	8,157	14	7.00	
8.00 ADULTS & PEDIATRICS	30.00	0	26,046	14	8.00	
9.00 CORONARY CARE UNIT	32.00	0	1,281	14	9.00	
10.00 SUBPROVIDER - IPF	40.00	0	3,991	14	10.00	
12.00 OPERATING ROOM	50.00	0	35,495	14	12.00	
13.00 RECOVERY ROOM	51.00	0	911	14	13.00	
15.00 RADIOLOGY-DIAGNOSTIC	54.00	0	2,439	14	15.00	
16.00 RADIOLOGY-THERAPEUTIC	55.00	0	2,109	14	16.00	
17.00 CARDIAC CATHETERIZATION	59.00	0	9,426	14	17.00	
18.00 LABORATORY	60.00	0	2,927	14	18.00	
19.00 RESPIRATORY THERAPY	65.00	0	2,940	14	19.00	
20.00 PHYSICAL THERAPY	66.00	0	20,563	14	20.00	
21.00 SPEECH PATHOLOGY	68.00	0	810	14	21.00	
22.00 ELECTROCARDIOLOGY	69.00	0	6,413	14	22.00	
23.00 ELECTROENCEPHALOGRAPHY	70.00	0	6,747	14	23.00	
24.00 RURAL HEALTH CLINIC-CASEY	88.00	0	868	14	24.00	
25.00 RURAL HEALTH CLINIC III-SULLIVAN	88.01	0	816	14	25.00	
26.00 RURAL HEALTH CLINIC III-NEOGA	88.02	0	678	14	26.00	
27.00 EMERGENCY	91.00	0	6,729	14	27.00	
28.00 HOME HEALTH AGENCY	101.00	0	9,995	14	28.00	
29.00 HOSPICE	116.00	0	196,762	14	29.00	
30.00 PHYSICIANS' PRIVATE OFFICES	192.00	0	45,223	14	30.00	
31.00 WELLNESS	194.00	0	7,733	14	31.00	
32.00 OCCUPATIONAL HEALTH	194.03	0	2,184	14	32.00	
33.00 MISC. NONREIMBURSABLE	194.05	0	2,718	14	33.00	
34.00 OTHER NONREIMB PROGRAM: PEACE MEAL	194.01	0	3,331	14	34.00	
35.00 DIETARY	10.00	0	250	14	35.00	
36.00 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	502	14	36.00	
37.00 RURAL HEALTH CLINIC V-MARTINSVILLE	88.04	0	2,188	14	37.00	
0		0	737,138			
<b>D - DEPRECIATION</b>						
1.00 ADMINISTRATIVE & GENERAL	5.00	0	14,338,577	9	1.00	
2.00	0.00	0	0	9	2.00	
0		0	14,338,577			
<b>E - CAFETERIA EXPENSE</b>						
1.00 DIETARY	10.00	1,025,590	1,039,636	0	1.00	
0		1,025,590	1,039,636			
<b>F - EMPLOYEE PHYSICALS/BENEF EXP</b>						
1.00 OCCUPATIONAL HEALTH	194.03	0	214,813	0	1.00	
0		0	214,813			
<b>G - EAP BENEFITS</b>						
1.00 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	22,587	0	1.00	
0		0	22,587			
<b>H - INTEREST EXPENSE</b>						
1.00 ADMINISTRATIVE & GENERAL	5.00	0	1,830,632	11	1.00	
0		0	1,830,632			
<b>I - NURSRY/L&amp;D EXP</b>						
1.00 ADULTS & PEDIATRICS	30.00	1,300,918	0	0	1.00	
2.00	0.00	0	0	0	2.00	
0		1,300,918	0			

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Worksheet A-6

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Decreases							
Cost Center	Line #	Salary	Other	Wkst. A-7	Ref.		
6.00	7.00	8.00	9.00	10.00			
<b>J - PHYSN PROF LIAB EXP</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,158,318	0	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	
5.00		0.00	0	0	0	5.00	
6.00		0.00	0	0	0	6.00	
7.00		0.00	0	0	0	7.00	
8.00		0.00	0	0	0	8.00	
9.00		0.00	0	0	0	9.00	
10.00		0.00	0	0	0	10.00	
11.00		0.00	0	0	0	11.00	
12.00		0.00	0	0	0	12.00	
13.00		0.00	0	0	0	13.00	
14.00		0.00	0	0	0	14.00	
15.00		0.00	0	0	0	15.00	
			0	2,158,318			
<b>K - RHC V-LAB STAFF EXPENSE</b>							
1.00	RURAL HEALTH CLINIC V-MARTINSVILLE	88.04	23,871	1,826	0	1.00	
	TOTALS		23,871	1,826			
500.00	Grand Total: Decreases		2,646,272	32,919,884		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140189

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
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	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	3,405,746	147,600	0	147,600	0	1.00
2.00	Land Improvements	8,640,109	131,323	0	131,323	49,503	2.00
3.00	Buildings and Fixtures	131,605,603	3,895,004	0	3,895,004	534,348	3.00
4.00	Building Improvements	607,552	0	0	0	63,724	4.00
5.00	Fixed Equipment	16,280,584	989,496	0	989,496	31,335	5.00
6.00	Movable Equipment	76,481,336	11,861,303	0	11,861,303	2,808,976	6.00
7.00	HIT designated Assets	684,552	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	237,705,482	17,024,726	0	17,024,726	3,487,886	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	237,705,482	17,024,726	0	17,024,726	3,487,886	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	3,553,346	0				1.00
2.00	Land Improvements	8,721,929	0				2.00
3.00	Buildings and Fixtures	134,966,259	0				3.00
4.00	Building Improvements	543,828	0				4.00
5.00	Fixed Equipment	17,238,745	0				5.00
6.00	Movable Equipment	85,533,663	0				6.00
7.00	HIT designated Assets	684,552	0				7.00
8.00	Subtotal (sum of lines 1-7)	251,242,322	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	251,242,322	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140189

Period:  
From 07/01/2015  
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Worksheet A-7  
Part II  
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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	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	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	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140189

Period:  
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Worksheet A-7  
Part III  
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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	5,590,163	0	5,590,163	0.389869	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,748,415	0	8,748,415	0.610131	0	2.00
3.00	Total (sum of lines 1-2)	14,338,578	0	14,338,578	1.000000	0	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	0	5,590,163	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	8,748,414	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	14,338,577	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	196,769	0	0	0	5,786,932	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	737,138	9,485,552	2.00
3.00	Total (sum of lines 1-2)	196,769	0	0	737,138	15,272,484	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140189

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

Worksheet A-8

Date/Time Prepared:  
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center	Line #	Wkst.	A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00		0	7.00
8.00 Television and radio service (chapter 21)			0		0.00		0	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-25,608,877					0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0				0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-959,171	CAFETERIA		11.00		0	14.00
15.00 Rental of quarters to employee and others			0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00		0	16.00
17.00 Sale of drugs to other than patients			0		0.00		0	17.00
18.00 Sale of medical records and abstracts	B	-119,521	MEDICAL RECORDS & LIBRARY		16.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines	B	-462	HOUSEKEEPING		9.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00 INVESTMENT INCOME	B	-1,633,863	CAP REL COSTS-BLDG & FIXT		1.00		11	33.00
35.00 A&G OTHER INCOME	B	-744,792	ADMINISTRATIVE & GENERAL		5.00		0	35.00

Provider CCN: 140189  
 Period: From 07/01/2015 To 06/30/2016  
 Worksheet A-8  
 Date/Time Prepared: 11/18/2016 1:05 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
36.00 DIETARY OUTREACH REVENUE	B	-650	DIETARY	10.00	0	36.00
37.00 FACILITIES SVC OTHER REV	B	-332	OPERATION OF PLANT	7.00	0	37.00
38.00 W&C (BABY CLASSES), 4W MISC	B	-12,333	ADULTS & PEDIATRICS	30.00	0	38.00
38.01 XRAY OTHER REVENUE	B	-391	RADIOLOGY-DIAGNOSTIC	54.00	0	38.01
39.00 PHYSICAL THERAPY OTHER REV	B	-5,675	PHYSICAL THERAPY	66.00	0	39.00
39.01 MEDICAID ASSESSMENT TAX	A	-4,451,801	ADMINISTRATIVE & GENERAL	5.00	0	39.01
41.00 SPEECH/AUDIO OTHER REV	B	-971,241	SPEECH PATHOLOGY	68.00	0	41.00
42.00 CARDIOLOGY OTHER REV	B	-72,679	ELECTROCARDIOLOGY	69.00	0	42.00
43.00 EMERGENCY (EMS) OTHER REV	B	-221,612	EMERGENCY	91.00	0	43.00
44.00 AHA/IIHA LOBBYING FEES	A	-34,695	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00 CRNA S&W (EMPLOYEES)	A	-1,833,980	ANESTHESIOLOGY	53.00	0	45.00
45.01 CRNA (BENEFIT EXP)	A	-312,282	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.01
45.02		0		0.00	0	45.02
45.03		0		0.00	0	45.03
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-36,984,357				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: 140189

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

Worksheet A-8-2

Date/Time Prepared:  
11/18/2016 1:05 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	3,767,220	3,767,220	0	142,500	0	1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	1,728,721	1,728,721	0	138,700	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	4,050,465	4,050,465	0	167,500	0	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	4,400,741	4,400,741	0	217,600	0	4.00
5.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	1,227,590	1,227,590	0	217,600	0	5.00
6.00	60.00	DR. A	795,801	771,767	24,034	208,000	63	6.00
7.00	65.00	RESPIRATORY THERAPY	149,072	149,072	0	159,800	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	2,577,056	2,577,056	0	159,800	0	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	639,530	639,530	0	159,800	0	9.00
10.00	91.00	DR. B	503,969	261,317	242,652	159,800	1,040	10.00
11.00	91.00	AGGREGATE-EMERGENCY	5,868,765	5,868,765	0	159,800	0	11.00
200.00			25,708,930	25,442,244	266,686		1,103	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	33,835	0	116,434	1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	10,989	0	23,718	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	32,924	0	468,972	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	13,595	0	38,811	4.00
5.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	0	0	0	0	29,109	5.00
6.00	60.00	DR. A	6,300	315	1,295	39	12,937	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	11,783	0	12,937	9.00
10.00	91.00	DR. B	79,900	3,995	5,238	2,522	22,640	10.00
11.00	91.00	AGGREGATE-EMERGENCY	0	0	53,028	0	219,932	11.00
200.00			86,200	4,310	162,687	2,561	945,490	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	3,767,220		1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	1,728,721		2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	4,050,465		3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	4,400,741		4.00
5.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	0	0	0	1,227,590		5.00
6.00	60.00	DR. A	391	6,730	17,304	789,071		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	149,072		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	2,577,056		8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	639,530		9.00
10.00	91.00	DR. B	10,901	93,323	149,329	410,646		10.00
11.00	91.00	AGGREGATE-EMERGENCY	0	0	0	5,868,765		11.00
200.00			11,292	100,053	166,633	25,608,877		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140189

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/18/2016 1:05 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	5,786,932	5,786,932			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	9,485,552		9,485,552		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	26,912,679	43,068	3,689	26,959,436	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	27,519,572	535,342	2,534,139	2,592,702	5.00
7.00 00700	OPERATION OF PLANT	4,554,896	397,412	331,969	244,236	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	646,778	12,504	0	5,592	8.00
9.00 00900	HOUSEKEEPING	1,950,160	109,249	18,807	309,008	9.00
10.00 01000	DIETARY	893,923	77,283	90,183	90,817	10.00
11.00 01100	CAFETERIA	1,106,055	46,777	19,508	209,604	11.00
13.00 01300	NURSING ADMINISTRATION	2,595,736	16,683	2,681	464,226	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,502,160	75,105	180,364	131,429	14.00
15.00 01500	PHARMACY	1,903,687	34,556	32,092	322,967	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,416,130	45,376	149,865	303,135	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	14,167,618	394,316	450,303	3,074,999	30.00
32.00 03200	CORONARY CARE UNIT	2,852,398	57,786	221,340	367,031	32.00
40.00 04000	SUBPROVIDER - I/PF	1,557,931	102,632	20,054	615,474	40.00
43.00 04300	NURSERY	543,116	7,264	20,718	105,608	43.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	7,694,387	424,786	1,224,061	1,048,697	50.00
51.00 05100	RECOVERY ROOM	1,605,971	100,101	18,484	268,928	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	874,820	16,566	87,048	160,266	52.00
53.00 05300	ANESTHESIOLOGY	1,546,571	7,606	106,492	1,166,472	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,429,677	178,173	657,214	1,331,207	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	1,344,059	80,556	170,939	437,960	55.00
56.00 05600	RADIOISOTOPE	2,613,954	22,935	696,183	259,398	56.00
57.00 05700	CT SCAN	1,205,695	17,967	163,432	98,767	57.00
58.00 05800	MRI	911,021	24,054	397,849	79,809	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,012,572	33,461	281,074	107,690	59.00
60.00 06000	LABORATORY	9,598,559	144,606	397,306	1,036,600	60.00
65.00 06500	RESPIRATORY THERAPY	1,356,797	18,190	75,376	214,066	65.00
66.00 06600	PHYSICAL THERAPY	2,781,640	169,283	37,782	383,401	66.00
67.00 06700	OCCUPATIONAL THERAPY	551,026	4,969	5,512	100,199	67.00
68.00 06800	SPEECH PATHOLOGY	373,296	36,428	26,163	168,941	68.00
69.00 06900	ELECTROCARDIOLOGY	1,507,316	67,499	83,782	282,731	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,705,293	54,053	48,322	227,457	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,948,531	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	5,670,927	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	12,528,761	0	0	0	73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	600,343	32,013	3,430	115,491	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC-CASEY	398,166	156,050	5,831	56,403	88.00
88.01 08801	RURAL HEALTH CLINIC II-SULLIVAN	551,554	77,860	6,903	81,156	88.01
88.02 08802	RURAL HEALTH CLINIC III-NEOGA	812,561	30,506	7,851	137,849	88.02
88.03 08803	RURAL HEALTH CLINIC IV-NEWTON	622,639	34,556	33,640	90,372	88.03
88.04 08805	RURAL HEALTH CLINIC V-MARTINSVILLE	1,034,900	99,559	23,679	165,468	88.04
91.00 09100	EMERGENCY	5,384,365	210,068	143,839	1,945,803	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100	HOME HEALTH AGENCY	4,365,930	46,977	129,343	726,030	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00 11600	HOSPICE	2,457,013	17,661	61	314,587	116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	184,883,667	4,061,836	8,865,308	19,842,576	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	40,306,744	1,197,172	365,800	6,328,242	192.00
194.00 07950	WELLNESS	1,262,063	274,329	90,048	147,932	194.00
194.01 07953	OTHER NONREIMB PROGRAM: PEACE MEAL	2,898,877	0	68,785	244,946	194.01
194.02 07951	LIFELINE	136,534	2,826	0	4,101	194.02
194.03 07952	OCCUPATIONAL HEALTH	496,248	34,273	8,138	101,096	194.03
194.05 07954	MISC. NONREIMBURSABLE	1,949,873	216,496	87,473	290,543	194.05
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	231,934,006	5,786,932	9,485,552	26,959,436	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part I Date/Time Prepared: 11/18/2016 1:05 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		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		
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00		
5.00	00500	ADMINISTRATIVE & GENERAL	33,181,755			5.00		
7.00	00700	OPERATION OF PLANT	922,985	6,451,498		7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	111,001	16,767	792,642	8.00		
9.00	00900	HOUSEKEEPING	398,547	146,498	32,829	2,965,098	9.00	
10.00	01000	DIETARY	185,349	103,633	7,952	0	1,407,140	10.00
11.00	01100	CAFETERIA	230,716	62,726	0	134,992	0	11.00
13.00	01300	NURSING ADMINISTRATION	514,093	22,372	0	22,709	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	315,378	100,713	12,653	37,848	0	14.00
15.00	01500	PHARMACY	382,867	46,338	0	20,186	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	486,577	60,848	0	16,401	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	3,019,664	528,761	238,352	31,856	1,206,929	30.00
32.00	03200	CORONARY CARE UNIT	584,084	77,488	18,788	87,682	44,060	32.00
40.00	04000	SUBPROVIDER - IPF	383,332	137,625	14,418	99,352	121,001	40.00
43.00	04300	NURSERY	112,976	9,741	6,890	0	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,734,933	569,621	122,378	784,405	6,762	50.00
51.00	05100	RECOVERY ROOM	332,812	134,231	56,717	201,858	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	190,106	22,214	18,618	0	0	52.00
53.00	05300	ANESTHESIOLOGY	471,991	10,199	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	934,297	238,922	33,183	67,181	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	339,495	108,023	18,378	50,464	0	55.00
56.00	05600	RADIOISOTOPE	599,763	30,755	19,498	37,848	0	56.00
57.00	05700	CT SCAN	248,064	24,093	15,372	15,139	0	57.00
58.00	05800	MRI	235,856	32,255	6,735	6,308	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	239,539	44,870	11,515	31,540	0	59.00
60.00	06000	LABORATORY	1,866,012	193,910	206	117,645	0	60.00
65.00	06500	RESPIRATORY THERAPY	277,876	24,393	0	12,616	0	65.00
66.00	06600	PHYSICAL THERAPY	562,973	227,002	8,388	101,560	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	110,472	6,663	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	100,976	48,849	143	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	324,105	90,513	7,308	84,528	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	339,764	72,483	1,039	42,895	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	659,207	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	946,761	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,091,677	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	125,426	42,928	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC-CASEY	102,916	209,256	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II-SULLIVAN	119,782	104,407	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III-NEOGA	165,075	40,907	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV-NEWTON	130,423	46,338	0	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V-MARTINSVILLE	220,976	133,505	0	0	0	88.04
91.00	09100	EMERGENCY	1,282,856	281,692	141,268	304,363	28,388	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	879,539	62,995	0	15,139	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
116.00	11600	HOSPICE	465,677	23,682	0	10,093	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,746,918	4,138,216	792,628	2,334,608	1,407,140	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,046,718	1,605,357	14	516,945	0	192.00
194.00	07950	WELLNESS	296,231	367,864	0	9,462	0	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	536,345	0	0	0	0	194.01
194.02	07951	LIFELINE	23,951	3,789	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	106,807	45,959	0	25,232	0	194.03
194.05	07954	MISC. NONREIMBURSABLE	424,785	290,313	0	78,851	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	33,181,755	6,451,498	792,642	2,965,098	1,407,140	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140189

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/18/2016 1:05 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
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	1,810,378					11.00
13.00	01300		3,692,243				13.00
14.00	01400	23,033	0	2,378,683			14.00
15.00	01500	32,246	0	0	2,774,939		15.00
16.00	01600	55,279	0	0	0	3,533,611	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	390,020	1,819,893	0	0	166,029	30.00
32.00	03200	42,995	211,425	0	0	23,825	32.00
40.00	04000	39,924	149,475	0	0	20,565	40.00
43.00	04300	13,820	69,381	0	0	11,836	43.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	130,519	657,957	0	0	410,353	50.00
51.00	05100	33,781	168,123	0	0	98,856	51.00
52.00	05200	18,426	100,479	0	0	30,925	52.00
53.00	05300	26,104	15,399	0	0	74,225	53.00
54.00	05400	61,421	0	0	0	171,175	54.00
55.00	05500	27,639	0	0	0	68,301	55.00
56.00	05600	24,568	0	0	0	194,784	56.00
57.00	05700	13,820	0	0	0	331,551	57.00
58.00	05800	9,213	0	0	0	146,047	58.00
59.00	05900	10,749	0	0	0	96,344	59.00
60.00	06000	142,803	0	0	0	276,485	60.00
65.00	06500	29,175	0	0	0	65,408	65.00
66.00	06600	39,924	0	0	0	89,998	66.00
67.00	06700	10,749	0	0	0	14,815	67.00
68.00	06800	16,891	0	0	0	16,003	68.00
69.00	06900	36,852	0	0	0	46,225	69.00
70.00	07000	26,104	0	0	0	44,048	70.00
71.00	07100	0	0	1,165,555	0	125,329	71.00
72.00	07200	0	0	1,213,128	0	131,268	72.00
73.00	07300	0	0	0	2,774,939	519,793	73.00
75.00	07500	0	0	0	0	0	75.00
76.00	03550	21,497	0	0	0	981	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	1,817	88.00
88.01	08801	0	0	0	0	3,227	88.01
88.02	08802	0	0	0	0	4,783	88.02
88.03	08803	0	0	0	0	4,224	88.03
88.04	08805	0	0	0	0	6,485	88.04
91.00	09100	127,448	500,111	0	0	275,005	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	19,962	0	0	0	30,299	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	9,213	0	0	0	32,602	116.00
118.00		1,487,918	3,692,243	2,378,683	2,774,939	3,533,611	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	271,787	0	0	0	0	192.00
194.00	07950	29,175	0	0	0	0	194.00
194.01	07953	0	0	0	0	0	194.01
194.02	07951	1,536	0	0	0	0	194.02
194.03	07952	13,820	0	0	0	0	194.03
194.05	07954	6,142	0	0	0	0	194.05
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,810,378	3,692,243	2,378,683	2,774,939	3,533,611	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140189

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/18/2016 1:05 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	25,488,740	0	25,488,740	30.00
32.00	03200	CORONARY CARE UNIT	4,588,902	0	4,588,902	32.00
40.00	04000	SUBPROVIDER - IPF	3,261,783	0	3,261,783	40.00
43.00	04300	NURSERY	901,350	0	901,350	43.00
45.00	04500	NURSING FACILITY	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	14,808,859	0	14,808,859	50.00
51.00	05100	RECOVERY ROOM	3,019,862	0	3,019,862	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,519,468	0	1,519,468	52.00
53.00	05300	ANESTHESIOLOGY	3,425,059	0	3,425,059	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,102,450	0	7,102,450	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,645,814	0	2,645,814	55.00
56.00	05600	RADIOISOTOPE	4,499,686	0	4,499,686	56.00
57.00	05700	CT SCAN	2,133,900	0	2,133,900	57.00
58.00	05800	MRI	1,849,147	0	1,849,147	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,869,354	0	1,869,354	59.00
60.00	06000	LABORATORY	13,774,132	0	13,774,132	60.00
65.00	06500	RESPIRATORY THERAPY	2,073,897	0	2,073,897	65.00
66.00	06600	PHYSICAL THERAPY	4,401,951	0	4,401,951	66.00
67.00	06700	OCCUPATIONAL THERAPY	804,405	0	804,405	67.00
68.00	06800	SPEECH PATHOLOGY	787,690	0	787,690	68.00
69.00	06900	ELECTROCARDIOLOGY	2,530,859	0	2,530,859	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,561,458	0	2,561,458	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,898,622	0	5,898,622	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,962,084	0	7,962,084	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,915,170	0	17,915,170	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	942,109	0	942,109	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC-CASEY	930,439	0	930,439	88.00
88.01	08801	RURAL HEALTH CLINIC II-SULLIVAN	944,889	0	944,889	88.01
88.02	08802	RURAL HEALTH CLINIC III-NEOGA	1,199,532	0	1,199,532	88.02
88.03	08803	RURAL HEALTH CLINIC IV-NEWTON	962,192	0	962,192	88.03
88.04	08805	RURAL HEALTH CLINIC V-MARTINSVILLE	1,684,572	0	1,684,572	88.04
91.00	09100	EMERGENCY	10,625,206	0	10,625,206	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100	HOME HEALTH AGENCY	6,276,214	0	6,276,214	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00	11600	HOSPICE	3,330,589	0	3,330,589	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	162,720,384	0	162,720,384	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	58,638,779	0	58,638,779	192.00
194.00	07950	WELLNESS	2,477,104	0	2,477,104	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	3,748,953	0	3,748,953	194.01
194.02	07951	LIFELINE	172,737	0	172,737	194.02
194.03	07952	OCCUPATIONAL HEALTH	831,573	0	831,573	194.03
194.05	07954	MISC. NONREIMBURSABLE	3,344,476	0	3,344,476	194.05
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	231,934,006	0	231,934,006	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 11/18/2016 1:05 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	43,068	3,689	46,757	46,757 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	535,342	2,534,139	3,069,481	4,491 5.00
7.00 00700	OPERATION OF PLANT	0	397,412	331,969	729,381	423 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	12,504	0	12,504	10 8.00
9.00 00900	HOUSEKEEPING	0	109,249	18,807	128,056	535 9.00
10.00 01000	DIETARY	0	77,283	48,183	125,466	157 10.00
11.00 01100	CAFETERIA	0	46,777	19,508	66,285	363 11.00
13.00 01300	NURSING ADMINISTRATION	0	16,683	2,681	19,364	804 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	75,105	180,364	255,469	228 14.00
15.00 01500	PHARMACY	0	34,556	32,092	66,648	559 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	45,376	149,865	195,241	525 16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	394,316	450,303	844,619	5,326 30.00
32.00 03200	CORONARY CARE UNIT	0	57,786	221,340	279,126	636 32.00
40.00 04000	SUBPROVIDER - I/PF	0	102,632	20,054	122,686	1,066 40.00
43.00 04300	NURSERY	0	7,264	20,718	27,982	183 43.00
45.00 04500	NURSING FACILITY	0	0	0	0	0 45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	424,786	1,224,061	1,648,847	1,816 50.00
51.00 05100	RECOVERY ROOM	0	100,101	18,484	118,585	466 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	16,566	87,048	103,614	278 52.00
53.00 05300	ANESTHESIOLOGY	0	7,606	106,492	114,098	2,020 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	178,173	657,214	835,387	2,306 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	80,556	170,939	251,495	759 55.00
56.00 05600	RADIOISOTOPE	0	22,935	696,183	719,118	449 56.00
57.00 05700	CT SCAN	0	17,967	163,432	181,399	171 57.00
58.00 05800	MRI	0	24,054	397,849	421,903	138 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	33,461	281,074	314,535	187 59.00
60.00 06000	LABORATORY	0	144,606	397,306	541,912	1,796 60.00
65.00 06500	RESPIRATORY THERAPY	0	18,190	75,376	93,566	371 65.00
66.00 06600	PHYSICAL THERAPY	0	169,283	37,782	207,065	664 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	4,969	5,512	10,481	174 67.00
68.00 06800	SPEECH PATHOLOGY	0	36,428	26,163	62,591	293 68.00
69.00 06900	ELECTROCARDIOLOGY	0	67,499	83,782	151,281	490 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	54,053	48,322	102,375	394 70.00
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
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	32,013	3,430	35,443	200 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC-CASEY	0	156,050	5,831	161,881	98 88.00
88.01 08801	RURAL HEALTH CLINIC II -SULLIVAN	0	77,860	6,903	84,763	141 88.01
88.02 08802	RURAL HEALTH CLINIC III -NEOGA	0	30,506	7,851	38,357	239 88.02
88.03 08803	RURAL HEALTH CLINIC IV-NEWTON	0	34,556	33,640	68,196	157 88.03
88.04 08805	RURAL HEALTH CLINIC V-MARTINSVILLE	0	99,559	23,679	123,238	287 88.04
91.00 09100	EMERGENCY	0	210,068	143,839	353,907	3,370 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100	HOME HEALTH AGENCY	0	46,977	129,343	176,320	1,258 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00 11600	HOSPICE	0	17,661	61	17,722	545 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	4,061,836	8,865,308	12,927,144	34,373 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	1,197,172	365,800	1,562,972	11,019 192.00
194.00 07950	WELLNESS	0	274,329	90,048	364,377	256 194.00
194.01 07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	68,785	68,785	424 194.01
194.02 07951	LIFELINE	0	2,826	0	2,826	7 194.02
194.03 07952	OCCUPATIONAL HEALTH	0	34,273	8,138	42,411	175 194.03
194.05 07954	MISC. NONREIMBURSABLE	0	216,496	87,473	303,969	503 194.05
200.00	Cross Foot Adjustments				0	0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	5,786,932	9,485,552	15,272,484	46,757 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 11/18/2016 1:05 pm		
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		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
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,073,972			5.00
7.00	00700	OPERATION OF PLANT	85,504	815,308		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,283	2,119	24,916	8.00
9.00	00900	HOUSEKEEPING	36,921	18,514	1,032	185,058
10.00	01000	DIETARY	17,170	13,097	250	0
11.00	01100	CAFETERIA	21,373	7,927	0	8,425
13.00	01300	NURSING ADMINISTRATION	47,625	2,827	0	1,417
14.00	01400	CENTRAL SERVICES & SUPPLY	29,216	12,728	398	2,362
15.00	01500	PHARMACY	35,468	5,856	0	1,260
16.00	01600	MEDICAL RECORDS & LIBRARY	45,076	7,690	0	1,024
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	279,737	66,822	7,491	1,988
32.00	03200	CORONARY CARE UNIT	54,109	9,793	591	5,472
40.00	04000	SUBPROVIDER - IPF	35,511	17,392	453	6,201
43.00	04300	NURSERY	10,466	1,231	217	0
45.00	04500	NURSING FACILITY	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	160,722	71,986	3,847	48,956
51.00	05100	RECOVERY ROOM	30,831	16,963	1,783	12,598
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,611	2,807	585	0
53.00	05300	ANESTHESIOLOGY	43,725	1,289	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	86,552	30,194	1,043	4,193
55.00	05500	RADIOLOGY-THERAPEUTIC	31,450	13,651	578	3,150
56.00	05600	RADIOISOTOPE	55,561	3,887	613	2,362
57.00	05700	CT SCAN	22,980	3,045	483	945
58.00	05800	MRI	21,849	4,076	212	394
59.00	05900	CARDIAC CATHETERIZATION	22,191	5,670	362	1,968
60.00	06000	LABORATORY	172,865	24,505	6	7,342
65.00	06500	RESPIRATORY THERAPY	25,742	3,083	0	787
66.00	06600	PHYSICAL THERAPY	52,153	28,687	264	6,339
67.00	06700	OCCUPATIONAL THERAPY	10,234	842	0	0
68.00	06800	SPEECH PATHOLOGY	9,354	6,173	4	0
69.00	06900	ELECTROCARDIOLOGY	30,025	11,439	230	5,276
70.00	07000	ELECTROENCEPHALOGRAPHY	31,475	9,160	33	2,677
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,068	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	87,707	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	193,770	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	11,619	5,425	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC-CASEY	9,534	26,445	0	0
88.01	08801	RURAL HEALTH CLINIC II-SULLIVAN	11,096	13,194	0	0
88.02	08802	RURAL HEALTH CLINIC III-NEOGA	15,292	5,170	0	0
88.03	08803	RURAL HEALTH CLINIC IV-NEWTON	12,082	5,856	0	0
88.04	08805	RURAL HEALTH CLINIC V-MARTINSVILLE	20,471	16,872	0	0
91.00	09100	EMERGENCY	118,842	35,599	4,441	18,996
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				3,150
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100	HOME HEALTH AGENCY	81,479	7,961	0	945
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00	11600	HOSPICE	43,140	2,993	0	630
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,199,879	522,968	24,916	145,707
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	745,501	202,876	0	32,264
194.00	07950	WELLNESS	27,442	46,489	0	591
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	49,686	0	0	0
194.02	07951	LIFELINE	2,219	479	0	0
194.03	07952	OCCUPATIONAL HEALTH	9,894	5,808	0	1,575
194.05	07954	MISC. NONREIMBURSABLE	39,351	36,688	0	4,921
200.00		Cross Foot Adjustments				
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	3,073,972	815,308	24,916	185,058

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140189		Period: From 07/01/2015 To 06/30/2016		Worksheet B Part II Date/Time Prepared: 11/18/2016 1:05 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
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	104,373					11.00
13.00	01300		75,135				13.00
14.00	01400			301,729			14.00
15.00	01500				111,650		15.00
16.00	01600					252,743	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	22,484	37,034	0	0	11,878	30.00
32.00	03200	2,479	4,302	0	0	1,705	32.00
40.00	04000	2,302	3,042	0	0	1,471	40.00
43.00	04300	797	1,412	0	0	847	43.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	7,525	13,389	0	0	29,358	50.00
51.00	05100	1,948	3,421	0	0	7,072	51.00
52.00	05200	1,062	2,045	0	0	2,212	52.00
53.00	05300	1,505	313	0	0	5,310	53.00
54.00	05400	3,541	0	0	0	12,246	54.00
55.00	05500	1,593	0	0	0	4,886	55.00
56.00	05600	1,416	0	0	0	13,935	56.00
57.00	05700	797	0	0	0	23,720	57.00
58.00	05800	531	0	0	0	10,449	58.00
59.00	05900	620	0	0	0	6,893	59.00
60.00	06000	8,233	0	0	0	19,781	60.00
65.00	06500	1,682	0	0	0	4,680	65.00
66.00	06600	2,302	0	0	0	6,439	66.00
67.00	06700	620	0	0	0	1,060	67.00
68.00	06800	974	0	0	0	1,145	68.00
69.00	06900	2,125	0	0	0	3,307	69.00
70.00	07000	1,505	0	0	0	3,151	70.00
71.00	07100	0	0	147,847	0	8,966	71.00
72.00	07200	0	0	153,882	0	9,391	72.00
73.00	07300	0	0	0	111,650	37,127	73.00
75.00	07500	0	0	0	0	0	75.00
76.00	03550	1,239	0	0	0	70	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	130	88.00
88.01	08801	0	0	0	0	231	88.01
88.02	08802	0	0	0	0	342	88.02
88.03	08803	0	0	0	0	302	88.03
88.04	08805	0	0	0	0	464	88.04
91.00	09100	7,348	10,177	0	0	19,675	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	1,151	0	0	0	2,168	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	531	0	0	0	2,332	116.00
118.00		85,782	75,135	301,729	111,650	252,743	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	15,669	0	0	0	0	192.00
194.00	07950	1,682	0	0	0	0	194.00
194.01	07953	0	0	0	0	0	194.01
194.02	07951	89	0	0	0	0	194.02
194.03	07952	797	0	0	0	0	194.03
194.05	07954	354	0	0	0	0	194.05
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		104,373	75,135	301,729	111,650	252,743	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 11/18/2016 1:05 pm
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
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				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	1,411,303	0	1,411,303	30.00
32.00	03200	363,102	0	363,102	32.00
40.00	04000	203,551	0	203,551	40.00
43.00	04300	43,135	0	43,135	43.00
45.00	04500	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	1,987,196	0	1,987,196	50.00
51.00	05100	193,667	0	193,667	51.00
52.00	05200	130,214	0	130,214	52.00
53.00	05300	168,260	0	168,260	53.00
54.00	05400	975,462	0	975,462	54.00
55.00	05500	307,562	0	307,562	55.00
56.00	05600	797,341	0	797,341	56.00
57.00	05700	233,540	0	233,540	57.00
58.00	05800	459,552	0	459,552	58.00
59.00	05900	352,426	0	352,426	59.00
60.00	06000	776,440	0	776,440	60.00
65.00	06500	129,911	0	129,911	65.00
66.00	06600	303,913	0	303,913	66.00
67.00	06700	23,411	0	23,411	67.00
68.00	06800	80,534	0	80,534	68.00
69.00	06900	204,173	0	204,173	69.00
70.00	07000	150,770	0	150,770	70.00
71.00	07100	217,881	0	217,881	71.00
72.00	07200	250,980	0	250,980	72.00
73.00	07300	342,547	0	342,547	73.00
75.00	07500	0	0	0	75.00
76.00	03550	53,996	0	53,996	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	198,088	0	198,088	88.00
88.01	08801	109,425	0	109,425	88.01
88.02	08802	59,400	0	59,400	88.02
88.03	08803	86,593	0	86,593	88.03
88.04	08805	161,332	0	161,332	88.04
91.00	09100	575,505	0	575,505	91.00
92.00	09200		0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	271,282	0	271,282	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
116.00	11600	67,893	0	67,893	116.00
118.00		11,690,385	0	11,690,385	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
192.00	19200	2,570,301	0	2,570,301	192.00
194.00	07950	440,837	0	440,837	194.00
194.01	07953	118,895	0	118,895	194.01
194.02	07951	5,620	0	5,620	194.02
194.03	07952	60,660	0	60,660	194.03
194.05	07954	385,786	0	385,786	194.05
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		15,272,484	0	15,272,484	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189

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

Worksheet B-1  
Date/Time Prepared:  
11/18/2016 1:05 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	491,510				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		7,802,167			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,658	3,034	131,912,292		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	45,469	2,084,412	12,686,065	-33,181,755	5.00
7.00 00700	OPERATION OF PLANT	33,754	273,055	1,195,044	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,062	0	27,360	0	8.00
9.00 00900	HOUSEKEEPING	9,279	15,469	1,511,973	0	9.00
10.00 01000	DIETARY	6,564	39,632	444,368	0	10.00
11.00 01100	CAFETERIA	3,973	16,046	1,025,590	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,417	2,205	2,271,453	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	6,379	148,355	643,079	0	14.00
15.00 01500	PHARMACY	2,935	26,397	1,580,272	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,854	123,269	1,483,237	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	33,491	370,388	15,045,940	0	30.00
32.00 03200	CORONARY CARE UNIT	4,908	182,059	1,795,880	0	32.00
40.00 04000	SUBPROVIDER - I/PF	8,717	16,495	3,011,510	0	40.00
43.00 04300	NURSERY	617	17,041	516,737	0	43.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	36,079	1,006,829	5,131,264	0	50.00
51.00 05100	RECOVERY ROOM	8,502	15,204	1,315,861	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,407	71,600	784,181	0	52.00
53.00 05300	ANESTHESIOLOGY	646	87,593	5,707,537	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	15,133	540,579	6,513,581	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	6,842	140,603	2,142,932	0	55.00
56.00 05600	RADIOISOTOPE	1,948	572,632	1,269,230	0	56.00
57.00 05700	CT SCAN	1,526	134,428	483,268	0	57.00
58.00 05800	MRI	2,043	327,243	390,503	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	2,842	231,192	526,924	0	59.00
60.00 06000	LABORATORY	12,282	326,797	5,072,074	0	60.00
65.00 06500	RESPIRATORY THERAPY	1,545	61,999	1,047,424	0	65.00
66.00 06600	PHYSICAL THERAPY	14,378	31,077	1,875,977	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	422	4,534	490,275	0	67.00
68.00 06800	SPEECH PATHOLOGY	3,094	21,520	826,626	0	68.00
69.00 06900	ELECTROCARDIOLOGY	5,733	68,913	1,383,398	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	4,591	39,746	1,112,945	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,719	2,821	565,095	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC-CASEY	13,254	4,796	275,977	0	88.00
88.01 08801	RURAL HEALTH CLINIC II-SULLIVAN	6,613	5,678	397,097	0	88.01
88.02 08802	RURAL HEALTH CLINIC III-NEOGA	2,591	6,458	674,494	0	88.02
88.03 08803	RURAL HEALTH CLINIC IV-NEWTON	2,935	27,670	442,191	0	88.03
88.04 08805	RURAL HEALTH CLINIC V-MARTINSVILLE	8,456	19,477	809,634	0	88.04
91.00 09100	EMERGENCY	17,842	118,312	9,520,796	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100	HOME HEALTH AGENCY	3,990	106,389	3,552,456	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00 11600	HOSPICE	1,500	50	1,539,271	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	344,990	7,291,997	97,089,519	-33,181,755	142,239,712
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	101,681	300,882	30,964,078	0	192.00
194.00 07950	WELLNESS	23,300	74,067	723,830	0	194.00
194.01 07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	56,578	1,198,516	0	194.01
194.02 07951	LIFELINE	240	0	20,066	0	194.02
194.03 07952	OCCUPATIONAL HEALTH	2,911	6,694	494,661	0	194.03
194.05 07954	MISC. NONREIMBURSABLE	18,388	71,949	1,421,622	0	194.05
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	5,786,932	9,485,552	26,959,436		33,181,755
203.00	Unit cost multiplier (Wkst. B, Part I)	11.773783	1.215759	0.204374		0.166950

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189

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

Worksheet B-1

Date/Time Prepared:  
11/18/2016 1:05 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
204.00	Cost to be allocated (per Wkst. B, Part II)			46,757		3,073,972	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000354		0.015466	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189

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

Worksheet B-1

Date/Time Prepared:  
11/18/2016 1:05 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	408,629				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	1,125,215			8.00
9.00	00900	HOUSEKEEPING	9,279	46,603	9,401		9.00
10.00	01000	DIETARY	6,564	11,288	0	161,889	10.00
11.00	01100	CAFETERIA	3,973	0	428	0	1,179
13.00	01300	NURSING ADMINISTRATION	1,417	0	72	0	35
14.00	01400	CENTRAL SERVICES & SUPPLY	6,379	17,962	120	0	15
15.00	01500	PHARMACY	2,935	0	64	0	21
16.00	01600	MEDICAL RECORDS & LIBRARY	3,854	0	52	0	36
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	33,491	338,357	101	138,855	254
32.00	03200	CORONARY CARE UNIT	4,908	26,671	278	5,069	28
40.00	04000	SUBPROVIDER - IPF	8,717	20,468	315	13,921	26
43.00	04300	NURSERY	617	9,781	0	0	9
45.00	04500	NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	36,079	173,725	2,487	778	85
51.00	05100	RECOVERY ROOM	8,502	80,514	640	0	22
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,407	26,430	0	0	12
53.00	05300	ANESTHESIOLOGY	646	0	0	0	17
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,133	47,106	213	0	40
55.00	05500	RADIOLOGY-THERAPEUTIC	6,842	26,089	160	0	18
56.00	05600	RADIOISOTOPE	1,948	27,679	120	0	16
57.00	05700	CT SCAN	1,526	21,822	48	0	9
58.00	05800	MRI	2,043	9,561	20	0	6
59.00	05900	CARDIAC CATHETERIZATION	2,842	16,346	100	0	7
60.00	06000	LABORATORY	12,282	292	373	0	93
65.00	06500	RESPIRATORY THERAPY	1,545	0	40	0	19
66.00	06600	PHYSICAL THERAPY	14,378	11,908	322	0	26
67.00	06700	OCCUPATIONAL THERAPY	422	0	0	0	7
68.00	06800	SPEECH PATHOLOGY	3,094	203	0	0	11
69.00	06900	ELECTROCARDIOLOGY	5,733	10,374	268	0	24
70.00	07000	ELECTROENCEPHALOGRAPHY	4,591	1,475	136	0	17
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,719	0	0	0	14
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC-CASEY	13,254	0	0	0	0
88.01	08801	RURAL HEALTH CLINIC II-SULLIVAN	6,613	0	0	0	0
88.02	08802	RURAL HEALTH CLINIC III-NEOGA	2,591	0	0	0	0
88.03	08803	RURAL HEALTH CLINIC IV-NEWTON	2,935	0	0	0	0
88.04	08805	RURAL HEALTH CLINIC V-MARTINSVILLE	8,456	0	0	0	0
91.00	09100	EMERGENCY	17,842	200,541	965	3,266	83
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	3,990	0	48	0	13
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	HOSPICE	1,500	0	32	0	6
118.00		SUBTOTALS (SUM OF LINES 1-117)	262,109	1,125,195	7,402	161,889	969
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	101,681	20	1,639	0	177
194.00	07950	WELLNESS	23,300	0	30	0	19
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	0	0	0
194.02	07951	LIFELINE	240	0	0	0	1
194.03	07952	OCCUPATIONAL HEALTH	2,911	0	80	0	9
194.05	07954	MISC. NONREIMBURSABLE	18,388	0	250	0	4
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	6,451,498	792,642	2,965,098	1,407,140	1,810,378
203.00		Unit cost multiplier (Wkst. B, Part I)	15.788155	0.704436	315.402404	8.692005	1,535.519932
204.00		Cost to be allocated (per Wkst. B, Part II)	815,308	24,916	185,058	156,140	104,373
205.00		Unit cost multiplier (Wkst. B, Part II)	1.995228	0.022143	19.684927	0.964488	88.526718

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189

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

Worksheet B-1

Date/Time Prepared:  
11/18/2016 1:05 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSNG HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
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					11.00
13.00	01300	896,758				13.00
14.00	01400	0	100			14.00
15.00	01500	0	0	100		15.00
16.00	01600	0	0	0	630,489,769	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	442,009	0	0	29,621,502	30.00
32.00	03200	51,350	0	0	4,250,757	32.00
40.00	04000	36,304	0	0	3,668,980	40.00
43.00	04300	16,851	0	0	2,111,691	43.00
45.00	04500	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	159,802	0	0	73,211,884	50.00
51.00	05100	40,833	0	0	17,637,075	51.00
52.00	05200	24,404	0	0	5,517,320	52.00
53.00	05300	3,740	0	0	13,242,683	53.00
54.00	05400	0	0	0	30,539,739	54.00
55.00	05500	0	0	0	12,185,715	55.00
56.00	05600	0	0	0	34,751,843	56.00
57.00	05700	0	0	0	59,152,667	57.00
58.00	05800	0	0	0	26,056,603	58.00
59.00	05900	0	0	0	17,188,901	59.00
60.00	06000	0	0	0	49,328,276	60.00
65.00	06500	0	0	0	11,669,607	65.00
66.00	06600	0	0	0	16,056,812	66.00
67.00	06700	0	0	0	2,643,157	67.00
68.00	06800	0	0	0	2,855,210	68.00
69.00	06900	0	0	0	8,247,190	69.00
70.00	07000	0	0	0	7,858,755	70.00
71.00	07100	0	49	0	22,360,129	71.00
72.00	07200	0	51	0	23,419,800	72.00
73.00	07300	0	0	100	92,787,902	73.00
75.00	07500	0	0	0	0	75.00
76.00	03550	0	0	0	174,963	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	0	0	0	324,259	88.00
88.01	08801	0	0	0	575,671	88.01
88.02	08802	0	0	0	853,424	88.02
88.03	08803	0	0	0	753,534	88.03
88.04	08805	0	0	0	1,157,011	88.04
91.00	09100	121,465	0	0	49,064,233	91.00
92.00	09200	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100	0	0	0	5,405,798	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00	11600	0	0	0	5,816,678	116.00
118.00		896,758	100	100	630,489,769	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00	19200	0	0	0	0	192.00
194.00	07950	0	0	0	0	194.00
194.01	07953	0	0	0	0	194.01
194.02	07951	0	0	0	0	194.02
194.03	07952	0	0	0	0	194.03
194.05	07954	0	0	0	0	194.05
200.00						200.00
201.00						201.00
202.00		3,692,243	2,378,683	2,774,939	3,533,611	202.00
203.00		4.117324	23,786.830000	27,749.390000	0.005605	203.00
204.00		75,135	301,729	111,650	252,743	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189

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

Worksheet B-1

Date/Time Prepared:  
11/18/2016 1:05 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
		(DIRECT NRSING HR)	(COSTED REQUIS.)				
205.00	Unit cost multiplier (Wkst. B, Part II)	0.083785	3,017.290000	1,116.500000	0.000401		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/18/2016 1:05 pm
			Title XVIII	Hospital	PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
			Total Costs	RCE Disallowance	Total Costs
	1.00	2.00	3.00	4.00	5.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		25,488,740	0	25,488,740
32.00	03200 CORONARY CARE UNIT		4,588,902	0	4,588,902
40.00	04000 SUBPROVIDER - I/PF		3,261,783	0	3,261,783
43.00	04300 NURSERY		901,350	0	901,350
45.00	04500 NURSING FACILITY		0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM		14,808,859	0	14,808,859
51.00	05100 RECOVERY ROOM		3,019,862	0	3,019,862
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,519,468	0	1,519,468
53.00	05300 ANESTHESIOLOGY		3,425,059	0	3,425,059
54.00	05400 RADIOLOGY-DIAGNOSTIC		7,102,450	0	7,102,450
55.00	05500 RADIOLOGY-THERAPEUTIC		2,645,814	0	2,645,814
56.00	05600 RADIOISOTOPE		4,499,686	0	4,499,686
57.00	05700 CT SCAN		2,133,900	0	2,133,900
58.00	05800 MRI		1,849,147	0	1,849,147
59.00	05900 CARDIAC CATHETERIZATION		1,869,354	0	1,869,354
60.00	06000 LABORATORY		13,774,132	17,304	13,791,436
65.00	06500 RESPIRATORY THERAPY	0	2,073,897	0	2,073,897
66.00	06600 PHYSICAL THERAPY	0	4,401,951	0	4,401,951
67.00	06700 OCCUPATIONAL THERAPY	0	804,405	0	804,405
68.00	06800 SPEECH PATHOLOGY	0	787,690	0	787,690
69.00	06900 ELECTROCARDIOLOGY		2,530,859	0	2,530,859
70.00	07000 ELECTROENCEPHALOGRAPHY		2,561,458	0	2,561,458
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		5,898,622	0	5,898,622
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		7,962,084	0	7,962,084
73.00	07300 DRUGS CHARGED TO PATIENTS		17,915,170	0	17,915,170
75.00	07500 ASC (NON-DISTINCT PART)		0	0	0
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		942,109	0	942,109
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC-CASEY		930,439	0	930,439
88.01	08801 RURAL HEALTH CLINIC II-SULLIVAN		944,889	0	944,889
88.02	08802 RURAL HEALTH CLINIC III-NEOGA		1,199,532	0	1,199,532
88.03	08803 RURAL HEALTH CLINIC IV-NEWTON		962,192	0	962,192
88.04	08805 RURAL HEALTH CLINIC V-MARTINSVILLE		1,684,572	0	1,684,572
91.00	09100 EMERGENCY		10,625,206	149,329	10,774,535
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		5,420,289	0	5,420,289
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100 HOME HEALTH AGENCY		6,276,214	0	6,276,214
<b>SPECIAL PURPOSE COST CENTERS</b>					
116.00	11600 HOSPICE		3,330,589	0	3,330,589
200.00	Subtotal (see instructions)	0	168,140,673	166,633	168,307,306
201.00	Less Observation Beds		5,420,289	0	5,420,289
202.00	Total (see instructions)	0	162,720,384	166,633	162,887,017

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140189		Period: From 07/01/2015 To 06/30/2016		Worksheet C Part I Date/Time Prepared: 11/18/2016 1:05 pm	
			Title XVIII		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	23,867,764		23,867,764			30.00
32.00	03200	CORONARY CARE UNIT	4,250,757		4,250,757			32.00
40.00	04000	SUBPROVIDER - IPF	3,668,980		3,668,980			40.00
43.00	04300	NURSERY	2,111,691		2,111,691			43.00
45.00	04500	NURSING FACILITY	0		0			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	15,364,262	57,847,622	73,211,884	0.202274	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,354,728	14,282,347	17,637,075	0.171222	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,258,709	258,611	5,517,320	0.275400	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,493,539	8,749,144	13,242,683	0.258638	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,207,723	26,332,016	30,539,739	0.232564	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	223,294	11,962,421	12,185,715	0.217124	0.000000	55.00
56.00	05600	RADIOISOTOPE	5,145,413	29,606,430	34,751,843	0.129480	0.000000	56.00
57.00	05700	CT SCAN	10,025,196	49,127,471	59,152,667	0.036074	0.000000	57.00
58.00	05800	MRI	1,948,977	24,107,626	26,056,603	0.070967	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,544,520	12,644,381	17,188,901	0.108754	0.000000	59.00
60.00	06000	LABORATORY	8,466,736	40,861,540	49,328,276	0.279234	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	9,156,631	2,512,976	11,669,607	0.177718	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,791,579	14,265,233	16,056,812	0.274149	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	383,846	2,259,311	2,643,157	0.304335	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	270,971	2,584,239	2,855,210	0.275878	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,804,921	6,442,269	8,247,190	0.306875	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	134,638	7,724,117	7,858,755	0.325937	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,416,265	12,943,864	22,360,129	0.263801	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,047,775	6,372,025	23,419,800	0.339972	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,247,628	68,540,274	92,787,902	0.193077	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	174,963	174,963	5.384618	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC-CASEY	0	324,259	324,259			88.00
88.01	08801	RURAL HEALTH CLINIC II-SULLIVAN	0	575,671	575,671			88.01
88.02	08802	RURAL HEALTH CLINIC III-NEOGA	0	853,424	853,424			88.02
88.03	08803	RURAL HEALTH CLINIC IV-NEWTON	0	753,534	753,534			88.03
88.04	08805	RURAL HEALTH CLINIC V-MARTINSVILLE	0	1,157,011	1,157,011			88.04
91.00	09100	EMERGENCY	9,753,843	39,310,390	49,064,233	0.216557	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,753,738	5,753,738	0.942047	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	0	5,405,798	5,405,798			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
116.00	11600	HOSPICE	0	5,816,678	5,816,678			116.00
200.00		Subtotal (see instructions)	170,940,386	459,549,383	630,489,769			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	170,940,386	459,549,383	630,489,769			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/18/2016 1:05 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
32.00	03200 CORONARY CARE UNIT			32.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
45.00	04500 NURSING FACILITY			45.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.202274		50.00
51.00	05100 RECOVERY ROOM	0.171222		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.275400		52.00
53.00	05300 ANESTHESIOLOGY	0.258638		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.232564		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.217124		55.00
56.00	05600 RADIOISOTOPE	0.129480		56.00
57.00	05700 CT SCAN	0.036074		57.00
58.00	05800 MRI	0.070967		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.108754		59.00
60.00	06000 LABORATORY	0.279585		60.00
65.00	06500 RESPIRATORY THERAPY	0.177718		65.00
66.00	06600 PHYSICAL THERAPY	0.274149		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.304335		67.00
68.00	06800 SPEECH PATHOLOGY	0.275878		68.00
69.00	06900 ELECTROCARDIOLOGY	0.306875		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.325937		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.263801		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.339972		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.193077		73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5.384618		76.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC-CASEY			88.00
88.01	08801 RURAL HEALTH CLINIC II-SULLIVAN			88.01
88.02	08802 RURAL HEALTH CLINIC III-NEOGA			88.02
88.03	08803 RURAL HEALTH CLINIC IV-NEWTON			88.03
88.04	08805 RURAL HEALTH CLINIC V-MARTINSVILLE			88.04
91.00	09100 EMERGENCY	0.219601		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.942047		92.00
	OTHER REIMBURSABLE COST CENTERS			
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
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

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/18/2016 1:05 pm
			Title XIX	Hospital	Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
			Total Costs	RCE Disallowance	Total Costs
	1.00	2.00	3.00	4.00	5.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		25,488,740	0	25,488,740
32.00	03200 CORONARY CARE UNIT		4,588,902	0	4,588,902
40.00	04000 SUBPROVIDER - I/PF		3,261,783	0	3,261,783
43.00	04300 NURSERY		901,350	0	901,350
45.00	04500 NURSING FACILITY		0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM		14,808,859	0	14,808,859
51.00	05100 RECOVERY ROOM		3,019,862	0	3,019,862
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,519,468	0	1,519,468
53.00	05300 ANESTHESIOLOGY		3,425,059	0	3,425,059
54.00	05400 RADIOLOGY-DIAGNOSTIC		7,102,450	0	7,102,450
55.00	05500 RADIOLOGY-THERAPEUTIC		2,645,814	0	2,645,814
56.00	05600 RADIOISOTOPE		4,499,686	0	4,499,686
57.00	05700 CT SCAN		2,133,900	0	2,133,900
58.00	05800 MRI		1,849,147	0	1,849,147
59.00	05900 CARDIAC CATHETERIZATION		1,869,354	0	1,869,354
60.00	06000 LABORATORY		13,774,132	17,304	13,791,436
65.00	06500 RESPIRATORY THERAPY	0	2,073,897	0	2,073,897
66.00	06600 PHYSICAL THERAPY	0	4,401,951	0	4,401,951
67.00	06700 OCCUPATIONAL THERAPY	0	804,405	0	804,405
68.00	06800 SPEECH PATHOLOGY	0	787,690	0	787,690
69.00	06900 ELECTROCARDIOLOGY		2,530,859	0	2,530,859
70.00	07000 ELECTROENCEPHALOGRAPHY		2,561,458	0	2,561,458
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		5,898,622	0	5,898,622
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		7,962,084	0	7,962,084
73.00	07300 DRUGS CHARGED TO PATIENTS		17,915,170	0	17,915,170
75.00	07500 ASC (NON-DISTINCT PART)		0	0	0
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		942,109	0	942,109
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC-CASEY		930,439	0	930,439
88.01	08801 RURAL HEALTH CLINIC II-SULLIVAN		944,889	0	944,889
88.02	08802 RURAL HEALTH CLINIC III-NEOGA		1,199,532	0	1,199,532
88.03	08803 RURAL HEALTH CLINIC IV-NEWTON		962,192	0	962,192
88.04	08805 RURAL HEALTH CLINIC V-MARTINSVILLE		1,684,572	0	1,684,572
91.00	09100 EMERGENCY		10,625,206	149,329	10,774,535
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		5,420,289	0	5,420,289
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100 HOME HEALTH AGENCY		6,276,214	0	6,276,214
<b>SPECIAL PURPOSE COST CENTERS</b>					
116.00	11600 HOSPICE		3,330,589	0	3,330,589
200.00	Subtotal (see instructions)	0	168,140,673	166,633	168,307,306
201.00	Less Observation Beds		5,420,289	0	5,420,289
202.00	Total (see instructions)	0	162,720,384	166,633	162,887,017

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140189		Period: From 07/01/2015 To 06/30/2016		Worksheet C Part I Date/Time Prepared: 11/18/2016 1:05 pm	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	23,867,764		23,867,764			30.00
32.00	03200	CORONARY CARE UNIT	4,250,757		4,250,757			32.00
40.00	04000	SUBPROVIDER - IPF	3,668,980		3,668,980			40.00
43.00	04300	NURSERY	2,111,691		2,111,691			43.00
45.00	04500	NURSING FACILITY	0		0			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	15,364,262	57,847,622	73,211,884	0.202274	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,354,728	14,282,347	17,637,075	0.171222	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,258,709	258,611	5,517,320	0.275400	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,493,539	8,749,144	13,242,683	0.258638	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,207,723	26,332,016	30,539,739	0.232564	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	223,294	11,962,421	12,185,715	0.217124	0.000000	55.00
56.00	05600	RADIOISOTOPE	5,145,413	29,606,430	34,751,843	0.129480	0.000000	56.00
57.00	05700	CT SCAN	10,025,196	49,127,471	59,152,667	0.036074	0.000000	57.00
58.00	05800	MRI	1,948,977	24,107,626	26,056,603	0.070967	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,544,520	12,644,381	17,188,901	0.108754	0.000000	59.00
60.00	06000	LABORATORY	8,466,736	40,861,540	49,328,276	0.279234	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	9,156,631	2,512,976	11,669,607	0.177718	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,791,579	14,265,233	16,056,812	0.274149	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	383,846	2,259,311	2,643,157	0.304335	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	270,971	2,584,239	2,855,210	0.275878	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,804,921	6,442,269	8,247,190	0.306875	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	134,638	7,724,117	7,858,755	0.325937	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,416,265	12,943,864	22,360,129	0.263801	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,047,775	6,372,025	23,419,800	0.339972	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,247,628	68,540,274	92,787,902	0.193077	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	174,963	174,963	5.384618	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC-CASEY	0	324,259	324,259	2.869432	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II-SULLIVAN	0	575,671	575,671	1.641370	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III-NEOGA	0	853,424	853,424	1.405552	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV-NEWTON	0	753,534	753,534	1.276906	0.000000	88.03
88.04	08805	RURAL HEALTH CLINIC V-MARTINSVILLE	0	1,157,011	1,157,011	1.455969	0.000000	88.04
91.00	09100	EMERGENCY	9,753,843	39,310,390	49,064,233	0.216557	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,753,738	5,753,738	0.942047	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	0	5,405,798	5,405,798			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
116.00	11600	HOSPICE	0	5,816,678	5,816,678			116.00
200.00		Subtotal (see instructions)	170,940,386	459,549,383	630,489,769			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	170,940,386	459,549,383	630,489,769			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/18/2016 1:05 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
32.00	03200 CORONARY CARE UNIT			32.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
45.00	04500 NURSING FACILITY			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC-CASEY	0.000000		88.00
88.01	08801 RURAL HEALTH CLINIC II-SULLIVAN	0.000000		88.01
88.02	08802 RURAL HEALTH CLINIC III-NEOGA	0.000000		88.02
88.03	08803 RURAL HEALTH CLINIC IV-NEWTON	0.000000		88.03
88.04	08805 RURAL HEALTH CLINIC V-MARTINSVILLE	0.000000		88.04
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00	10100 HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
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: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part I Date/Time Prepared: 11/18/2016 1:05 pm
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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)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,411,303	0	1,411,303	24,970	56.52	30.00
32.00	CORONARY CARE UNIT	363,102	0	363,102	2,318	156.64	32.00
40.00	SUBPROVIDER - IPF	203,551	0	203,551	3,146	64.70	40.00
43.00	NURSERY	43,135	0	43,135	1,348	32.00	43.00
45.00	NURSING FACILITY	0	0	0	0	0.00	45.00
200.00	Total (Lines 30-199)	2,021,091		2,021,091	31,782		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	10,355	585,265	30.00
32.00	CORONARY CARE UNIT	1,188	186,088	32.00
40.00	SUBPROVIDER - IPF	1,085	70,200	40.00
43.00	NURSERY	0	0	43.00
45.00	NURSING FACILITY	0	0	45.00
200.00	Total (Lines 30-199)	12,628	841,553	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Prepared: 11/18/2016 1:05 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	PPS		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,987,196	73,211,884	0.027143	7,473,370	202,850	50.00
51.00	05100	RECOVERY ROOM	193,667	17,637,075	0.010981	1,246,323	13,686	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	130,214	5,517,320	0.023601	14,010	331	52.00
53.00	05300	ANESTHESIOLOGY	168,260	13,242,683	0.012706	1,786,853	22,704	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	975,462	30,539,739	0.031941	2,856,845	91,250	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	307,562	12,185,715	0.025240	119,622	3,019	55.00
56.00	05600	RADIOISOTOPE	797,341	34,751,843	0.022944	2,766,788	63,481	56.00
57.00	05700	CT SCAN	233,540	59,152,667	0.003948	6,062,865	23,936	57.00
58.00	05800	MRI	459,552	26,056,603	0.017637	1,066,424	18,809	58.00
59.00	05900	CARDIAC CATHETERIZATION	352,426	17,188,901	0.020503	1,631,016	33,441	59.00
60.00	06000	LABORATORY	776,440	49,328,276	0.015740	4,808,769	75,690	60.00
65.00	06500	RESPIRATORY THERAPY	129,911	11,669,607	0.011132	4,828,439	53,750	65.00
66.00	06600	PHYSICAL THERAPY	303,913	16,056,812	0.018927	981,330	18,574	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,411	2,643,157	0.008857	233,524	2,068	67.00
68.00	06800	SPEECH PATHOLOGY	80,534	2,855,210	0.028206	139,783	3,943	68.00
69.00	06900	ELECTROCARDIOLOGY	204,173	8,247,190	0.024757	981,133	24,290	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	150,770	7,858,755	0.019185	78,145	1,499	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	217,881	22,360,129	0.009744	4,066,786	39,627	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	250,980	23,419,800	0.010717	7,734,921	82,895	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	342,547	92,787,902	0.003692	12,760,118	47,110	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	53,996	174,963	0.308614	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC-CASEY	198,088	324,259	0.610894	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II-SULLIVAN	109,425	575,671	0.190083	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III-NEOGA	59,400	853,424	0.069602	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV-NEWTON	86,593	753,534	0.114916	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V-MARTINSVILLE	161,332	1,157,011	0.139439	0	0	88.04
91.00	09100	EMERGENCY	575,505	49,064,233	0.011730	5,450,430	63,934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	300,121	5,753,738	0.052161	0	0	92.00
200.00		Total (lines 50-199)	9,630,240	585,368,101		67,087,494	886,887	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140189		Period: From 07/01/2015 To 06/30/2016		Worksheet D Part III Date/Time Prepared: 11/18/2016 1:05 pm	
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	0	0	0	0	0	30.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
200.00		Total (lines 30-199)	0	0	0	0	0	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	24,970	0.00	10,355	0		30.00
32.00	03200	CORONARY CARE UNIT	2,318	0.00	1,188	0		32.00
40.00	04000	SUBPROVIDER - IPF	3,146	0.00	1,085	0		40.00
43.00	04300	NURSERY	1,348	0.00	0	0		43.00
45.00	04500	NURSING FACILITY	0	0.00	0	0		45.00
200.00		Total (lines 30-199)	31,782		12,628	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/18/2016 1:05 pm
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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			
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC-CASEY	0	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II-SULLIVAN	0	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III-NEOGA	0	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV-NEWTON	0	0	0	0	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V-MARTINSVILLE	0	0	0	0	0	0	88.04
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140189

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/18/2016 1:05 pm

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)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	73,211,884	0.000000	0.000000	7,473,370	50.00
51.00	05100	RECOVERY ROOM	0	17,637,075	0.000000	0.000000	1,246,323	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,517,320	0.000000	0.000000	14,010	52.00
53.00	05300	ANESTHESIOLOGY	0	13,242,683	0.000000	0.000000	1,786,853	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,539,739	0.000000	0.000000	2,856,845	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	12,185,715	0.000000	0.000000	119,622	55.00
56.00	05600	RADIOISOTOPE	0	34,751,843	0.000000	0.000000	2,766,788	56.00
57.00	05700	CT SCAN	0	59,152,667	0.000000	0.000000	6,062,865	57.00
58.00	05800	MRI	0	26,056,603	0.000000	0.000000	1,066,424	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	17,188,901	0.000000	0.000000	1,631,016	59.00
60.00	06000	LABORATORY	0	49,328,276	0.000000	0.000000	4,808,769	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,669,607	0.000000	0.000000	4,828,439	65.00
66.00	06600	PHYSICAL THERAPY	0	16,056,812	0.000000	0.000000	981,330	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,643,157	0.000000	0.000000	233,524	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,855,210	0.000000	0.000000	139,783	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,247,190	0.000000	0.000000	981,133	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,858,755	0.000000	0.000000	78,145	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	22,360,129	0.000000	0.000000	4,066,786	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,419,800	0.000000	0.000000	7,734,921	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	92,787,902	0.000000	0.000000	12,760,118	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	174,963	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC-CASEY	0	324,259	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II-SULLIVAN	0	575,671	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III-NEOGA	0	853,424	0.000000	0.000000	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV-NEWTON	0	753,534	0.000000	0.000000	0	88.03
88.04	08805	RURAL HEALTH CLINIC V-MARTINSVILLE	0	1,157,011	0.000000	0.000000	0	88.04
91.00	09100	EMERGENCY	0	49,064,233	0.000000	0.000000	5,450,430	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,753,738	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	585,368,101			67,087,494	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/18/2016 1:05 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	19,565,161	0	50.00
51.00	05100 RECOVERY ROOM	0	2,400,019	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	582	0	52.00
53.00	05300 ANESTHESIOLOGY	0	2,538,353	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	9,156,107	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	4,159,012	0	55.00
56.00	05600 RADIOISOTOPE	0	7,108,262	0	56.00
57.00	05700 CT SCAN	0	14,177,603	0	57.00
58.00	05800 MRI	0	6,326,522	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	3,859,848	0	59.00
60.00	06000 LABORATORY	0	3,646,207	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	600,686	0	65.00
66.00	06600 PHYSICAL THERAPY	0	208,447	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	7,439	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	264,488	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,860,533	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1,688,974	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,054,981	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2,254,443	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	26,530,441	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC-CASEY	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II-SULLIVAN	0	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III-NEOGA	0	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV-NEWTON	0	0	0	88.03
88.04	08805 RURAL HEALTH CLINIC V-MARTINSVILLE	0	0	0	88.04
91.00	09100 EMERGENCY	0	9,218,954	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,282,627	0	92.00
200.00	Total (lines 50-199)	0	121,909,689	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/18/2016 1:05 pm
		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	0.202274	19,565,161	0	0	3,957,523	50.00
51.00	05100 RECOVERY ROOM	0.171222	2,400,019	0	0	410,936	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.275400	582	0	0	160	52.00
53.00	05300 ANESTHESIOLOGY	0.258638	2,538,353	0	0	656,515	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.232564	9,156,107	0	0	2,129,381	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.217124	4,159,012	0	0	903,021	55.00
56.00	05600 RADIOISOTOPE	0.129480	7,108,262	0	0	920,378	56.00
57.00	05700 CT SCAN	0.036074	14,177,603	0	0	511,443	57.00
58.00	05800 MRI	0.070967	6,326,522	0	0	448,974	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.108754	3,859,848	0	0	419,774	59.00
60.00	06000 LABORATORY	0.279234	3,646,207	0	0	1,018,145	60.00
65.00	06500 RESPIRATORY THERAPY	0.177718	600,686	9,935	0	106,753	65.00
66.00	06600 PHYSICAL THERAPY	0.274149	208,447	0	0	57,146	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.304335	7,439	0	0	2,264	67.00
68.00	06800 SPEECH PATHOLOGY	0.275878	264,488	0	0	72,966	68.00
69.00	06900 ELECTROCARDIOLOGY	0.306875	1,860,533	0	0	570,951	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.325937	1,688,974	0	0	550,499	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.263801	4,054,981	0	0	1,069,708	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.339972	2,254,443	0	0	766,447	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.193077	26,530,441	0	44,420	5,122,418	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5.384618	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC-CASEY	0.000000				0	88.00
88.01	08801 RURAL HEALTH CLINIC II-SULLIVAN	0.000000				0	88.01
88.02	08802 RURAL HEALTH CLINIC III-NEOGA	0.000000				0	88.02
88.03	08803 RURAL HEALTH CLINIC IV-NEWTON	0.000000				0	88.03
88.04	08805 RURAL HEALTH CLINIC V-MARTINSVILLE	0.000000				0	88.04
91.00	09100 EMERGENCY	0.216557	9,218,954	0	0	1,996,429	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.942047	2,282,627	0	0	2,150,342	92.00
200.00	Subtotal (see instructions)		121,909,689	9,935	44,420	23,842,173	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		121,909,689	9,935	44,420	23,842,173	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/18/2016 1:05 pm
		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
51.00	05100 RECOVERY ROOM	0	0	51.00
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
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	1,766	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
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	8,576	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC-CASEY	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II-SULLIVAN	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III-NEOGA	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV-NEWTON	0	0	88.03
88.04	08805 RURAL HEALTH CLINIC V-MARTINSVILLE	0	0	88.04
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	1,766	8,576	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	1,766	8,576	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140189 Component CCN: 14S189		Period: From 07/01/2015 To 06/30/2016		Worksheet D Part II Date/Time Prepared: 11/18/2016 1:05 pm	
		Title XVIII		Subprovider - IPF		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	1,987,196	73,211,884	0.027143	513	14 50.00
51.00	05100	RECOVERY ROOM	193,667	17,637,075	0.010981	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	130,214	5,517,320	0.023601	0	0 52.00
53.00	05300	ANESTHESIOLOGY	168,260	13,242,683	0.012706	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	975,462	30,539,739	0.031941	17,187	549 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	307,562	12,185,715	0.025240	0	0 55.00
56.00	05600	RADIOISOTOPE	797,341	34,751,843	0.022944	10,894	250 56.00
57.00	05700	CT SCAN	233,540	59,152,667	0.003948	61,970	245 57.00
58.00	05800	MRI	459,552	26,056,603	0.017637	42,171	744 58.00
59.00	05900	CARDIAC CATHETERIZATION	352,426	17,188,901	0.020503	0	0 59.00
60.00	06000	LABORATORY	776,440	49,328,276	0.015740	140,124	2,206 60.00
65.00	06500	RESPIRATORY THERAPY	129,911	11,669,607	0.011132	83,786	933 65.00
66.00	06600	PHYSICAL THERAPY	303,913	16,056,812	0.018927	7,177	136 66.00
67.00	06700	OCCUPATIONAL THERAPY	23,411	2,643,157	0.008857	1,308	12 67.00
68.00	06800	SPEECH PATHOLOGY	80,534	2,855,210	0.028206	411	12 68.00
69.00	06900	ELECTROCARDIOLOGY	204,173	8,247,190	0.024757	14,319	354 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	150,770	7,858,755	0.019185	1,286	25 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	217,881	22,360,129	0.009744	7,290	71 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	250,980	23,419,800	0.010717	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	342,547	92,787,902	0.003692	168,629	623 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0 75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	53,996	174,963	0.308614	0	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC-CASEY	198,088	324,259	0.610894	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II-SULLIVAN	109,425	575,671	0.190083	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III-NEOGA	59,400	853,424	0.069602	0	0 88.02
88.03	08803	RURAL HEALTH CLINIC IV-NEWTON	86,593	753,534	0.114916	0	0 88.03
88.04	08805	RURAL HEALTH CLINIC V-MARTINSVILLE	161,332	1,157,011	0.139439	0	0 88.04
91.00	09100	EMERGENCY	575,505	49,064,233	0.011730	255,370	2,995 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,753,738	0.000000	0	0 92.00
200.00		Total (lines 50-199)	9,330,119	585,368,101		812,435	9,169 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140189 Component CCN: 14S189	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/18/2016 1:05 pm
	Title XVIII	Subprovider - IPF	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	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
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
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC-CASEY	0	0	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II-SULLIVAN	0	0	0	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III-NEOGA	0	0	0	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV-NEWTON	0	0	0	0	0	88.03
88.04	08805 RURAL HEALTH CLINIC V-MARTINSVILLE	0	0	0	0	0	88.04
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140189 Component CCN: 14S189	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/18/2016 1:05 pm
Title XVIII		Subprovider - IPF	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	0	73,211,884	0.000000	0.000000	513	50.00
51.00	05100	RECOVERY ROOM	0	17,637,075	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,517,320	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	13,242,683	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,539,739	0.000000	0.000000	17,187	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	12,185,715	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	34,751,843	0.000000	0.000000	10,894	56.00
57.00	05700	CT SCAN	0	59,152,667	0.000000	0.000000	61,970	57.00
58.00	05800	MRI	0	26,056,603	0.000000	0.000000	42,171	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	17,188,901	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	49,328,276	0.000000	0.000000	140,124	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,669,607	0.000000	0.000000	83,786	65.00
66.00	06600	PHYSICAL THERAPY	0	16,056,812	0.000000	0.000000	7,177	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,643,157	0.000000	0.000000	1,308	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,855,210	0.000000	0.000000	411	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,247,190	0.000000	0.000000	14,319	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,858,755	0.000000	0.000000	1,286	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	22,360,129	0.000000	0.000000	7,290	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,419,800	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	92,787,902	0.000000	0.000000	168,629	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	174,963	0.000000	0.000000	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC-CASEY	0	324,259	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II-SULLIVAN	0	575,671	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III-NEOGA	0	853,424	0.000000	0.000000	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV-NEWTON	0	753,534	0.000000	0.000000	0	88.03
88.04	08805	RURAL HEALTH CLINIC V-MARTINSVILLE	0	1,157,011	0.000000	0.000000	0	88.04
91.00	09100	EMERGENCY	0	49,064,233	0.000000	0.000000	255,370	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,753,738	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	585,368,101			812,435	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/18/2016 1:05 pm
	Component CCN: 14S189	Title XVIII	Subprovider - IPF 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
51.00	05100 RECOVERY ROOM	0	0	0	51.00
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
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MRI	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC-CASEY	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II-SULLIVAN	0	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III-NEOGA	0	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV-NEWTON	0	0	0	88.03
88.04	08805 RURAL HEALTH CLINIC V-MARTINSVILLE	0	0	0	88.04
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/18/2016 1:05 pm
Cost Center Description		Title XVIII	Hospital	PPS
		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)		24,970	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		24,970	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)		19,660	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)		10,355	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)		25,488,740	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)		25,488,740	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)		25,488,740	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)		1,020.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		10,570,073	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)		10,570,073	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140189		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 11/18/2016 1:05 pm	
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)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT							43.00
44.00 CORONARY CARE UNIT	4,588,902	2,318	1,979.68	1,188	2,351,860		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)					13,982,325		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					26,904,258		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)					771,353		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					886,887		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,658,240		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					25,246,018		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)					5,310		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,020.77		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					5,420,289		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140189		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/18/2016 1:05 pm	
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	1,411,303	25,488,740	0.055370	5,420,289	300,121	90.00
91.00	Nursing School cost	0	25,488,740	0.000000	5,420,289	0	91.00
92.00	Allied health cost	0	25,488,740	0.000000	5,420,289	0	92.00
93.00	All other Medical Education	0	25,488,740	0.000000	5,420,289	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1
		Component CCN: 14S189		Date/Time Prepared: 11/18/2016 1:05 pm
		Title XVIII	Subprovider - IPF	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)		3,146	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,146	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)		3,146	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,085	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)		3,261,783	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)		3,261,783	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)		3,261,783	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)		1,036.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,124,928	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,124,928	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140189		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1	
		Component CCN: 14S189				Date/Time Prepared: 11/18/2016 1:05 pm	
		Title XVIII		Subprovider - IPF		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
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT							43.00
44.00 CORONARY CARE UNIT	0	0	0.00	0	0		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)				162,661		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				1,287,589		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				70,200		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				9,169		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				79,369		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				1,208,220		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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: 140189 Component CCN: 14S189		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/18/2016 1:05 pm	
		Title XVIII		Subprovider - IPF		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	203,551	3,261,783	0.062405	0	0	90.00
91.00	Nursing School cost	0	3,261,783	0.000000	0	0	91.00
92.00	Allied health cost	0	3,261,783	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,261,783	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/18/2016 1:05 pm	
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		11,434,618	30.00
32.00	03200	CORONARY CARE UNIT		2,114,883	32.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.202274	7,473,370	50.00
51.00	05100	RECOVERY ROOM	0.171222	1,246,323	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.275400	14,010	52.00
53.00	05300	ANESTHESIOLOGY	0.258638	1,786,853	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232564	2,856,845	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.217124	119,622	55.00
56.00	05600	RADIOISOTOPE	0.129480	2,766,788	56.00
57.00	05700	CT SCAN	0.036074	6,062,865	57.00
58.00	05800	MRI	0.070967	1,066,424	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.108754	1,631,016	59.00
60.00	06000	LABORATORY	0.279585	4,808,769	60.00
65.00	06500	RESPIRATORY THERAPY	0.177718	4,828,439	65.00
66.00	06600	PHYSICAL THERAPY	0.274149	981,330	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.304335	233,524	67.00
68.00	06800	SPEECH PATHOLOGY	0.275878	139,783	68.00
69.00	06900	ELECTROCARDIOLOGY	0.306875	981,133	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.325937	78,145	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.263801	4,066,786	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.339972	7,734,921	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.193077	12,760,118	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5.384618	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC-CASEY	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II-SULLIVAN	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III-NEOGA	0.000000		88.02
88.03	08803	RURAL HEALTH CLINIC IV-NEWTON	0.000000		88.03
88.04	08805	RURAL HEALTH CLINIC V-MARTINSVILLE	0.000000		88.04
91.00	09100	EMERGENCY	0.219601	5,450,430	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.942047	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		67,087,494	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)		67,087,494	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3	
		Component CCN: 14S189		Date/Time Prepared: 11/18/2016 1:05 pm	
		Title XVIII	Subprovider - IPF	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
32.00	03200 CORONARY CARE UNIT		0		32.00
40.00	04000 SUBPROVIDER - IPF		1,251,714		40.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.202274	513	104	50.00
51.00	05100 RECOVERY ROOM	0.171222	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.275400	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.258638	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.232564	17,187	3,997	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.217124	0	0	55.00
56.00	05600 RADIOISOTOPE	0.129480	10,894	1,411	56.00
57.00	05700 CT SCAN	0.036074	61,970	2,236	57.00
58.00	05800 MRI	0.070967	42,171	2,993	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.108754	0	0	59.00
60.00	06000 LABORATORY	0.279585	140,124	39,177	60.00
65.00	06500 RESPIRATORY THERAPY	0.177718	83,786	14,890	65.00
66.00	06600 PHYSICAL THERAPY	0.274149	7,177	1,968	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.304335	1,308	398	67.00
68.00	06800 SPEECH PATHOLOGY	0.275878	411	113	68.00
69.00	06900 ELECTROCARDIOLOGY	0.306875	14,319	4,394	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.325937	1,286	419	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.263801	7,290	1,923	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.339972	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.193077	168,629	32,558	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5.384618	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC-CASEY	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II-SULLIVAN	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III-NEOGA	0.000000		0	88.02
88.03	08803 RURAL HEALTH CLINIC IV-NEWTON	0.000000		0	88.03
88.04	08805 RURAL HEALTH CLINIC V-MARTINSVILLE	0.000000		0	88.04
91.00	09100 EMERGENCY	0.219601	255,370	56,080	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.942047	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		812,435	162,661	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		812,435		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/18/2016 1:05 pm
		Title XVIII	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)		4,636,971	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		14,716,047	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)		163,014	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)		70.49	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)		3.45	30.00
31.00	Percentage of Medicaid patient days (see instructions)		18.12	31.00
32.00	Sum of lines 30 and 31		21.57	32.00
33.00	Allowable disproportionate share percentage (see instructions)		7.01	33.00
34.00	Disproportionate share adjustment (see instructions)		339,162	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/18/2016 1:05 pm
		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)	0.000105058	0.000100583	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	803,446	644,349	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	202,513	482,382	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	684,895		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)	20,540,089		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	23,791,489		48.00
				<b>Amount</b>
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		23,791,489	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,537,797	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		0	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).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		25,329,286	59.00
60.00	Primary payer payments		10,494	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		25,318,792	61.00
62.00	Deductibles billed to program beneficiaries		2,518,432	62.00
63.00	Coinurance billed to program beneficiaries		21,602	63.00
64.00	Allowable bad debts (see instructions)		645,413	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		419,518	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		645,413	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		23,198,276	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)		61,815	70.93
70.94	HRR adjustment amount (see instructions)		-275,641	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/18/2016 1:05 pm	
		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)	0		0	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)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			60,380	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			22,924,070	71.00
71.01	Sequestration adjustment (see instructions)			458,481	71.01
72.00	Interim payments			22,628,033	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)			-162,444	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	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	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/18/2016 1:05 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		10,342	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		23,842,173	2.00
3.00	PPS payments		20,675,775	3.00
4.00	Outlier payment (see instructions)		205,810	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		10,342	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		54,355	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)		54,355	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)		54,355	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		44,013	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)		10,342	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)		20,881,585	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)		4,209,207	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)		16,682,720	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)		16,682,720	30.00
31.00	Primary payer payments		2,338	31.00
32.00	Subtotal (line 30 minus line 31)		16,680,382	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)		893,132	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		580,536	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		893,132	36.00
37.00	Subtotal (see instructions)		17,260,918	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		17,260,918	40.00
40.01	Sequestration adjustment (see instructions)		345,218	40.01
41.00	Interim payments		16,753,571	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		162,129	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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140189

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/18/2016 1:05 pm

		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		22,535,135		16,709,881	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	01/28/2016	35,892	01/28/2016	43,690	3.01	
3.02		01/28/2016	57,006		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)		92,898		43,690	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)		22,628,033		16,753,571	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		162,129	6.01	
6.02	SETTLEMENT TO PROGRAM		162,444		0	6.02	
7.00	Total Medicare program liability (see instructions)		22,465,589		16,915,700	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: 140189  
Component CCN: 14S189

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/18/2016 1:05 pm  
PPS

Title XVIII

Subprovider -  
IPF

		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		794,905		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		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)		794,905		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		55,813		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		850,718		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 140189		Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/18/2016 1:05 pm
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	6,483	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	11,543	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	2,523	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	21,978	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	630,489,769	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	14,132,701	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>			
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part II Date/Time Prepared: 11/18/2016 1:05 pm
		Component CCN: 14S189		
		Title XVIII	Subprovider - IPF	PPS
				1.00
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		962,417	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		8.595628	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$ .		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		962,417	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		962,417	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		962,417	18.00
19.00	Deductibles		148,988	19.00
20.00	Subtotal (line 18 minus line 19)		813,429	20.00
21.00	Coinsurance		2,205	21.00
22.00	Subtotal (line 20 minus line 21)		811,224	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		87,471	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		56,856	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		868,080	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		868,080	31.00
31.01	Sequestration adjustment (see instructions)		17,362	31.01
32.00	Interim payments		794,905	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)		55,813	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

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

Provider CCN: 140189

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

Worksheet G  
Date/Time Prepared:  
11/18/2016 1:05 pm

		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	26,917,485	0	0	0	1.00
2.00	Temporary investments	17,198,986	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	96,917,700	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-57,259,607	0	0	0	6.00
7.00	Inventory	3,518,805	0	0	0	7.00
8.00	Prepaid expenses	4,576,721	0	0	0	8.00
9.00	Other current assets	2,502,567	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)	94,372,657	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	3,553,346	0	0	0	12.00
13.00	Land improvements	8,670,430	0	0	0	13.00
14.00	Accumulated depreciation	-4,622,612	0	0	0	14.00
15.00	Buildings	172,785,522	0	0	0	15.00
16.00	Accumulated depreciation	-48,400,442	0	0	0	16.00
17.00	Leasehold improvements	543,828	0	0	0	17.00
18.00	Accumulated depreciation	-374,370	0	0	0	18.00
19.00	Fixed equipment	16,623,571	0	0	0	19.00
20.00	Accumulated depreciation	-11,933,952	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	86,888,864	0	0	0	23.00
24.00	Accumulated depreciation	-58,412,369	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	165,321,816	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	159,306,511	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	55,946,764	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	215,253,275	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	474,947,748	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	9,573,094	0	0	0	37.00
38.00	Salaries, wages, and fees payable	21,487,360	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	4,827,697	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	11,217,312	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	47,105,463	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	105,811,034	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	105,811,034	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	152,916,497	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	322,031,251				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	322,031,251	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	474,947,748	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140189

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

Worksheet G-1

Date/Time Prepared:  
11/18/2016 1:05 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		298,952,073		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		23,079,178				2.00
3.00	Total (sum of line 1 and line 2)		322,031,251		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		322,031,251		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		322,031,251		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140189

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/18/2016 1:05 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	23,867,764		23,867,764	1.00
2.00	SUBPROVIDER - IPF	3,668,980		3,668,980	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				7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	27,536,744		27,536,744	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT	4,250,757		4,250,757	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)	4,250,757		4,250,757	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	31,787,501		31,787,501	17.00
18.00	Ancillary services	137,040,444	405,176,873	542,217,317	18.00
19.00	Outpatient services	0	39,485,353	39,485,353	19.00
20.00	RURAL HEALTH CLINIC-CASEY	0	324,259	324,259	20.00
20.01	RURAL HEALTH CLINIC II-SULLIVAN	0	575,671	575,671	20.01
20.02	RURAL HEALTH CLINIC III-NEOGA	0	853,424	853,424	20.02
20.03	RURAL HEALTH CLINIC IV-NEWTON	0	753,534	753,534	20.03
20.04	RURAL HEALTH CLINIC V-MARTINSVILLE	0	1,157,011	1,157,011	20.04
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		5,405,798	5,405,798	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	5,816,678	5,816,678	26.00
27.00	NURSE IP, HOMKR, OCC HLTH, ACCRUALS.	1,677,778	1,563,538	3,241,316	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	170,505,723	461,112,139	631,617,862	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		268,918,363		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		268,918,363		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140189

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

Worksheet G-3

Date/Time Prepared:  
11/18/2016 1:05 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	631,617,862	1.00
2.00	Less contractual allowances and discounts on patients' accounts	394,422,729	2.00
3.00	Net patient revenues (line 1 minus line 2)	237,195,133	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	268,918,363	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-31,723,230	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	351,085	6.00
7.00	Income from investments	-4,357,817	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	265,401	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	908,534	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	123,105	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	23,623	21.00
22.00	Rental of hospital space	366,240	22.00
23.00	Governmental appropriations	0	23.00
24.00	PHYS REV, GRANTS, MISC OTHER	57,122,237	24.00
25.00	Total other income (sum of lines 6-24)	54,802,408	25.00
26.00	Total (line 5 plus line 25)	23,079,178	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	23,079,178	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140189

Period: From 07/01/2015

Worksheet H

HHA CCN: 147594

To 06/30/2016

Date/Time Prepared: 11/18/2016 1:05 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	941,137	248,568	80,255	191,396	293,255	1,754,611	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	1,683,412	0	0	0	0	1,683,412	6.00
7.00	522,866	0	0	0	0	522,866	7.00
8.00	223,676	0	0	0	0	223,676	8.00
9.00	43,864	0	0	0	0	43,864	9.00
10.00	35,476	0	0	0	0	35,476	10.00
11.00	102,025	0	0	0	0	102,025	11.00
12.00	0	0	0	0	0	0	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
24.00	3,552,456	248,568	80,255	191,396	293,255	4,365,930	24.00
	Reclassifi cation	Reclassifi ed 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	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	0	1,754,611	0	1,754,611			5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	0	1,683,412	0	1,683,412			6.00
7.00	0	522,866	0	522,866			7.00
8.00	0	223,676	0	223,676			8.00
9.00	0	43,864	0	43,864			9.00
10.00	0	35,476	0	35,476			10.00
11.00	0	102,025	0	102,025			11.00
12.00	0	0	0	0			12.00
13.00	0	0	0	0			13.00
14.00	0	0	0	0			14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	0	0	0			23.00
24.00	0	4,365,930	0	4,365,930			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: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet H-1 Part I Date/Time Prepared: 11/18/2016 1:05 pm
		HHA CCN: 147594	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				
		1.00	2.00				
<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	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	1,754,611	0	0	0	1,754,611	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	1,683,412	0	0	0	1,683,412	6.00
7.00	Physical Therapy	522,866	0	0	0	522,866	7.00
8.00	Occupational Therapy	223,676	0	0	0	223,676	8.00
9.00	Speech Pathology	43,864	0	0	0	43,864	9.00
10.00	Medical Social Services	35,476	0	0	0	35,476	10.00
11.00	Home Health Aide	102,025	0	0	0	102,025	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
<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)	4,365,930	0	0	0	4,365,930	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	1,754,611					5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	1,131,128	2,814,540				6.00
7.00	Physical Therapy	351,327	874,193				7.00
8.00	Occupational Therapy	150,293	373,969				8.00
9.00	Speech Pathology	29,473	73,337				9.00
10.00	Medical Social Services	23,837	59,313				10.00
11.00	Home Health Aide	68,553	170,578				11.00
12.00	Supplies (see instructions)	0	0				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
<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)		4,365,930				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 140189  
HHA CCN: 147594

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

Worksheet H-1  
Part II  
Date/Time Prepared:  
11/18/2016 1:05 pm  
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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
<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	-1,754,611	2,611,319
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	0	0	0	0	1,683,412
7.00	Physical Therapy	0	0	0	0	0	522,866
8.00	Occupational Therapy	0	0	0	0	0	223,676
9.00	Speech Pathology	0	0	0	0	0	43,864
10.00	Medical Social Services	0	0	0	0	0	35,476
11.00	Home Health Aide	0	0	0	0	0	102,025
12.00	Supplies (see instructions)	0	0	0	0	0	0
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	-1,754,611	2,611,319
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		1,754,611
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.671925

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140189  
HHA CCN: 147594

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

Worksheet H-2  
Part I  
Date/Time Prepared:  
11/18/2016 1:05 pm  
PPS

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00			4.00	4A
1.00	Administrative and General	0	46,977	129,343	726,030	902,350	150,647	1.00
2.00	Skilled Nursing Care	2,814,540	0	0	0	2,814,540	469,887	2.00
3.00	Physical Therapy	874,193	0	0	0	874,193	145,947	3.00
4.00	Occupational Therapy	373,969	0	0	0	373,969	62,434	4.00
5.00	Speech Pathology	73,337	0	0	0	73,337	12,244	5.00
6.00	Medical Social Services	59,313	0	0	0	59,313	9,902	6.00
7.00	Home Health Aide	170,578	0	0	0	170,578	28,478	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	4,365,930	46,977	129,343	726,030	5,268,280	879,539	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		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	62,995	0	15,139	0	19,962	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	62,995	0	15,139	0	19,962	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: 140189

Period: From 07/01/2015

Worksheet H-2

HHA CCN: 147594

To 06/30/2016

Part I  
Date/Time Prepared:  
11/18/2016 1:05 pm

Home Health Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	30,299	1,181,392	0	1,181,392	1.00
2.00	Skilled Nursing Care	0	0	0	3,284,427	0	3,284,427	2.00
3.00	Physical Therapy	0	0	0	1,020,140	0	1,020,140	3.00
4.00	Occupational Therapy	0	0	0	436,403	0	436,403	4.00
5.00	Speech Pathology	0	0	0	85,581	0	85,581	5.00
6.00	Medical Social Services	0	0	0	69,215	0	69,215	6.00
7.00	Home Health Aide	0	0	0	199,056	0	199,056	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	30,299	6,276,214	0	6,276,214	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		Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	761,595	4,046,022					2.00
3.00	Physical Therapy	236,551	1,256,691					3.00
4.00	Occupational Therapy	101,194	537,597					4.00
5.00	Speech Pathology	19,845	105,426					5.00
6.00	Medical Social Services	16,050	85,265					6.00
7.00	Home Health Aide	46,157	245,213					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
20.00	Total (sum of lines 1-19) (2)	1,181,392	6,276,214					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.	0.231881						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: 140189  
HHA CCN: 147594

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

Worksheet H-2  
Part II  
Date/Time Prepared:  
11/18/2016 1:05 pm  
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	3,990	106,389	3,552,456	0	902,350	3,990	1.00
2.00 Skilled Nursing Care	0	0	0	0	2,814,540	0	2.00
3.00 Physical Therapy	0	0	0	0	874,193	0	3.00
4.00 Occupational Therapy	0	0	0	0	373,969	0	4.00
5.00 Speech Pathology	0	0	0	0	73,337	0	5.00
6.00 Medical Social Services	0	0	0	0	59,313	0	6.00
7.00 Home Health Aide	0	0	0	0	170,578	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)	3,990	106,389	3,552,456		5,268,280	3,990	20.00
21.00 Total cost to be allocated	46,977	129,343	726,030		879,539	62,995	21.00
22.00 Unit cost multiplier	11.773684	1.215755	0.204374		0.166950	15.788221	22.00
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
	8.00	9.00	10.00	11.00	13.00	14.00	
1.00 Administrative and General	0	48	0	13	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	48	0	13	0	0	20.00
21.00 Total cost to be allocated	0	15,139	0	19,962	0	0	21.00
22.00 Unit cost multiplier	0.000000	315.395833	0.000000	1,535.538462	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140189  
HHA CCN: 147594

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

Worksheet H-2  
Part II  
Date/Time Prepared:  
11/18/2016 1:05 pm  
PPS

Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
	15.00	16.00		
1.00 Administrative and General	0	5,405,798		1.00
2.00 Skilled Nursing Care	0	0		2.00
3.00 Physical Therapy	0	0		3.00
4.00 Occupational Therapy	0	0		4.00
5.00 Speech Pathology	0	0		5.00
6.00 Medical Social Services	0	0		6.00
7.00 Home Health Aide	0	0		7.00
8.00 Supplies (see instructions)	0	0		8.00
9.00 Drugs	0	0		9.00
10.00 DME	0	0		10.00
11.00 Home Dialysis Aide Services	0	0		11.00
12.00 Respiratory Therapy	0	0		12.00
13.00 Private Duty Nursing	0	0		13.00
14.00 Clinic	0	0		14.00
15.00 Health Promotion Activities	0	0		15.00
16.00 Day Care Program	0	0		16.00
17.00 Home Delivered Meals Program	0	0		17.00
18.00 Homemaker Service	0	0		18.00
19.00 All Others (specify)	0	0		19.00
20.00 Total (sum of lines 1-19)	0	5,405,798		20.00
21.00 Total cost to be allocated	0	30,299		21.00
22.00 Unit cost multiplier	0.000000	0.005605		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet H-3 Part I Date/Time Prepared: 11/18/2016 1:05 pm		
				HHA CCN: 147594	Title XVIII	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	4,046,022		4,046,022	19,328	209.33	1.00
2.00	Physical Therapy	3.00	1,256,691	0	1,256,691	6,301	199.44	2.00
3.00	Occupational Therapy	4.00	537,597	0	537,597	2,317	232.02	3.00
4.00	Speech Pathology	5.00	105,426	0	105,426	297	354.97	4.00
5.00	Medical Social Services	6.00	85,265		85,265	296	288.06	5.00
6.00	Home Health Aide	7.00	245,213		245,213	2,838	86.40	6.00
7.00	Total (sum of lines 1-6)		6,276,214	0	6,276,214	31,377		7.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles								
Cost Center Description	Cost Limits	CBSA No. (1)	Part A					
	0	1.00	2.00	3.00	4.00	5.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care		99914	0	12,208			8.00
9.00	Physical Therapy		99914	0	3,871			9.00
10.00	Occupational Therapy		99914	0	1,508			10.00
11.00	Speech Pathology		99914	0	164			11.00
12.00	Medical Social Services		99914	0	203			12.00
13.00	Home Health Aide		99914	0	2,388			13.00
14.00	Total (sum of lines 8-13)			0	20,342			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	0	0	0	0.000000	15.00	
16.00	Cost of Drugs	9.00	0	0	0	0.000000	16.00	
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
Cost Center Description	Part A			Cost of Services				
	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	12,208		0	2,555,501	1.00	
2.00	Physical Therapy	0	3,871		0	772,032	2.00	
3.00	Occupational Therapy	0	1,508		0	349,886	3.00	
4.00	Speech Pathology	0	164		0	58,215	4.00	
5.00	Medical Social Services	0	203		0	58,476	5.00	
6.00	Home Health Aide	0	2,388		0	206,323	6.00	
7.00	Total (sum of lines 1-6)	0	20,342		0	4,000,433	7.00	
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	
9.00	Physical Therapy						9.00	
10.00	Occupational Therapy						10.00	
11.00	Speech Pathology						11.00	
12.00	Medical Social Services						12.00	
13.00	Home Health Aide						13.00	
14.00	Total (sum of lines 8-13)						14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 140189 HHA CCN: 147594	Period: From 07/01/2015 To 06/30/2016	Worksheet H-3 Part I Date/Time Prepared: 11/18/2016 1:05 pm PPS
				Title XVII I	Home Health Agency I	
Cost Center Description	Program Covered Charges			Cost of Services		
	Part A	Part B		Part A	Part B	
		Not Subject to Deductibles & Co Insurance	Subject to Deductibles & Co Insurance		Not Subject to Deductibles & Co Insurance	Subject to Deductibles & Co Insurance
	6.00	7.00	8.00	9.00	10.00	11.00
<b>Supplies and Drugs Cost Computations</b>						
15.00	Cost of Medical Supplies	0	0	0	0	0
16.00	Cost of Drugs		0	0	0	0
Total Program Cost (sum of col.s. 9-10)						
12.00						
<b>PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION</b>						
<b>Cost Per Visit Computation</b>						
1.00	Skilled Nursing Care	2,555,501				
2.00	Physical Therapy	772,032				
3.00	Occupational Therapy	349,886				
4.00	Speech Pathology	58,215				
5.00	Medical Social Services	58,476				
6.00	Home Health Aide	206,323				
7.00	Total (sum of lines 1-6)	4,000,433				
<b>Cost Center Description</b>						
12.00						
<b>Limitation Cost Computation</b>						
8.00	Skilled Nursing Care					
9.00	Physical Therapy					
10.00	Occupational Therapy					
11.00	Speech Pathology					
12.00	Medical Social Services					
13.00	Home Health Aide					
14.00	Total (sum of lines 8-13)					

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 140189 HHA CCN: 147594	Period: From 07/01/2015 To 06/30/2016	Worksheet H-3 Part II Date/Time Prepared: 11/18/2016 1:05 pm PPS
		Title XVIII	Home Health Agency I	

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	0.274149	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.304335	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology	68.00	0.275878	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.263801	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.193077	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 140189 HHA CCN: 147594	Period: From 07/01/2015 To 06/30/2016	Worksheet H-4 Part I-11 Date/Time Prepared: 11/18/2016 1:05 pm
		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	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
<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	2,892,844
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	120,757
13.00	Total PPS Reimbursement - LUPA Episodes		0	58,930
14.00	Total PPS Reimbursement - PEP Episodes		0	36,364
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	26,511
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	902
17.00	Total Other Payments		0	-63,349
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	3,072,959
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	3,072,959
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	3,072,959
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	3,072,959
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	3,072,959
31.01	Sequestration adjustment (see instructions)		0	0
32.00	Interim payments (see instructions)		0	3,072,959
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: 140189  
HHA CCN: 147594

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

Worksheet H-5  
Date/Time Prepared:  
11/18/2016 1:05 pm  
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		3,072,959	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		3,072,959	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		3,072,959	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: 140189

Period: From 07/01/2015

Worksheet K

Hospice CCN: 141599

To 06/30/2016

Date/Time Prepared: 11/18/2016 1:05 pm

		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	217,650	0	0	0	917,742	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	1,321,621	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	Total (sum of lines 1 thru 38)	1,539,271	0	0	0	917,742	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140189

Period: From 07/01/2015

Worksheet K

Hospice CCN: 141599

To 06/30/2016

Date/Time Prepared: 11/18/2016 1:05 pm

		Total (col. 5)	Reclassification	Subtotal (col. 6 ± col. 7)	Hospice I 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	1,135,392	0	1,135,392	0	1,135,392	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	1,321,621	0	1,321,621	0	1,321,621	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	Total (sum of lines 1 thru 38)	2,457,013	0	2,457,013	0	2,457,013	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140189

Period: From 07/01/2015

Worksheet K-1

Hospice CCN: 141599

To 06/30/2016

Date/Time Prepared: 11/18/2016 1:05 pm

		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	3.00
4.00	Transportation - Staff	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	5.00
6.00	Administrative and General	0	110,642	0	0	6.00
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care	0	0	197,065	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	0	0	0	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					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	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	110,642	197,065	0	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140189

Period: From 07/01/2015

Worksheet K-1

Hospice CCN: 141599

To 06/30/2016

Date/Time Prepared: 11/18/2016 1:05 pm

		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	107,008	217,650	6.00
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care		103,140	0	1,321,621	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	0	0	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	103,140	107,008	1,539,271	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140189  
 Hospice CCN: 141599

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

Worksheet K-4  
 Part I  
 Date/Time Prepared:  
 11/18/2016 1:05 pm

		Hospice I				
		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION
			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	4.00
5.00	Volunteer Service Coordination	0	0	0	0	5.00
6.00	Administrative and General	1,135,392	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care	1,321,621	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	0	0	0	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)	2,457,013	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140189

Period: From 07/01/2015

Worksheet K-4

Hospice CCN: 141599

To 06/30/2016

Part I  
Date/Time Prepared:  
11/18/2016 1:05 pm

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	Hospice I	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	1,135,392	1,135,392			6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	1,321,621	1,135,392		2,457,013	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	0	0		0	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	2,457,013			2,457,013	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189

Period: From 07/01/2015

Worksheet K-4

Hospice CCN: 141599

To 06/30/2016

Part II  
Date/Time Prepared:  
11/18/2016 1:05 pm

		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: 140189  
Hospice CCN: 141599

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

Worksheet K-4  
Part II  
Date/Time Prepared:  
11/18/2016 1:05 pm

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	Hospice I
		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	-1,135,392	1,321,621	6.00
<b>INPATIENT CARE SERVICE</b>				
7.00	Inpatient - General Care	0	1,321,621	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	0	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)		1,135,392	39.00
40.00	Unit Cost Multiplier		0.859090	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140189

Period: From 07/01/2015

Worksheet K-5

Hospice CCN: 141599

To 06/30/2016

Part I  
Date/Time Prepared:  
11/18/2016 1:05 pm

Cost Center Description		Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
			1.00	2.00			
		0	17,661	61	314,587	332,309	1.00
1.00	Administrative and General						
2.00	Inpatient - General Care	2,457,013	0	0	0	2,457,013	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)	2,457,013	17,661	61	314,587	2,789,322	34.00
35.00	Unit Cost Multiplier (see instructions)					0	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140189

Period:

Worksheet K-5

Hospice CCN: 141599

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

Part I  
Date/Time Prepared:  
11/18/2016 1:05 pm

Cost Center Description		Hospice I					
		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
1.00	Administrative and General	55,479	23,682	0	10,093	0	1.00
2.00	Inpatient - General Care	410,198	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)	465,677	23,682	0	10,093	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140189

Period: From 07/01/2015

Worksheet K-5

Hospice CCN: 141599

To 06/30/2016

Part I  
Date/Time Prepared:  
11/18/2016 1:05 pm

Cost Center Description		Hospice I					
		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	9,213	0	0	0	32,602	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)	9,213	0	0	0	32,602	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140189

Period: From 07/01/2015

Worksheet K-5

Hospice CCN: 141599

To 06/30/2016

Part I  
Date/Time Prepared:  
11/18/2016 1:05 pm

Cost Center Description		Hospice I					
		Subtotal (col.s. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (col.s. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (col.s. 26 ± 27)	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	463,378					1.00
2.00	Inpatient - General Care	2,867,211	0	2,867,211	463,378	3,330,589	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)	3,330,589	0	3,330,589		3,330,589	34.00
35.00	Unit Cost Multiplier (see instructions)				0.161613		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 140189  
Hospice CCN: 141599

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

Worksheet K-5  
Part II  
Date/Time Prepared:  
11/18/2016 1:05 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
1.00 Administrative and General	17,661	61	314,587	5A	332,309	1.00	
2.00 Inpatient - General Care	0	0	0		2,457,013	2.00	
3.00 Inpatient - Respite Care	0	0	0		0	3.00	
4.00 Physician Services	0	0	0		0	4.00	
5.00 Nursing Care	0	0	0		0	5.00	
6.00 Nursing Care-Continuous Home Care	0	0	0		0	6.00	
7.00 Physical Therapy	0	0	0		0	7.00	
8.00 Occupational Therapy	0	0	0		0	8.00	
9.00 Speech/ Language Pathology	0	0	0		0	9.00	
10.00 Medical Social Services	0	0	0		0	10.00	
11.00 Spiritual Counseling	0	0	0		0	11.00	
12.00 Dietary Counseling	0	0	0		0	12.00	
13.00 Counseling - Other	0	0	0		0	13.00	
14.00 Home Health Aide and Homemaker	0	0	0		0	14.00	
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0		0	15.00	
16.00 Other	0	0	0		0	16.00	
17.00 Drugs, Biological and Infusion Therapy	0	0	0		0	17.00	
18.00 Analgesics	0	0	0		0	18.00	
19.00 Sedatives / Hypnotics	0	0	0		0	19.00	
20.00 Other - Specify	0	0	0		0	20.00	
21.00 Durable Medical Equipment/Oxygen	0	0	0		0	21.00	
22.00 Patient Transportation	0	0	0		0	22.00	
23.00 Imaging Services	0	0	0		0	23.00	
24.00 Labs and Diagnostics	0	0	0		0	24.00	
25.00 Medical Supplies	0	0	0		0	25.00	
26.00 Outpatient Services (including E/R Dept.)	0	0	0		0	26.00	
27.00 Radiation Therapy	0	0	0		0	27.00	
28.00 Chemotherapy	0	0	0		0	28.00	
29.00 Other	0	0	0		0	29.00	
30.00 Bereavement Program Costs	0	0	0		0	30.00	
31.00 Volunteer Program Costs	0	0	0		0	31.00	
32.00 Fundraising	0	0	0		0	32.00	
33.00 Other Program Costs	0	0	0		0	33.00	
34.00 Total (sum of lines 1 thru 33) (2)	17,661	61	314,587		2,789,322	34.00	
35.00 Total cost to be allocated	17,661	61	314,587		465,677	35.00	
36.00 Unit Cost Multiplier (see instructions)	1.000000	1.000000	1.000000		0.166950	36.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 140189  
Hospice CCN: 141599

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

Worksheet K-5  
Part II  
Date/Time Prepared:  
11/18/2016 1:05 pm

Cost Center Description	Hospice I						
	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)		
	7.00	8.00	9.00	10.00	11.00		
1.00 Administrative and General	24,889	0	10,119	0	9,231	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)	24,889	0	10,119	0	9,231	34.00	
35.00 Total cost to be allocated	23,682	0	10,093	0	9,213	35.00	
36.00 Unit Cost Multiplier (see instructions)	0.951505	0.000000	0.997431	0.000000	0.998050	36.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 140189  
Hospice CCN: 141599

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

Worksheet K-5  
Part II  
Date/Time Prepared:  
11/18/2016 1:05 pm

Cost Center Description	Hospice I						
	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY			
	(DIRECT NRSING HR)	(COSTED REQUIS.)		(GROSS CHARGES)			
	13.00	14.00	15.00	16.00			
1.00 Administrative and General	0	0	0	32,690		1.00	
2.00 Inpatient - General Care	0	0	0	0		2.00	
3.00 Inpatient - Respite Care	0	0	0	0		3.00	
4.00 Physician Services	0	0	0	0		4.00	
5.00 Nursing Care	0	0	0	0		5.00	
6.00 Nursing Care-Continuous Home Care	0	0	0	0		6.00	
7.00 Physical Therapy	0	0	0	0		7.00	
8.00 Occupational Therapy	0	0	0	0		8.00	
9.00 Speech/ Language Pathology	0	0	0	0		9.00	
10.00 Medical Social Services	0	0	0	0		10.00	
11.00 Spiritual Counseling	0	0	0	0		11.00	
12.00 Dietary Counseling	0	0	0	0		12.00	
13.00 Counseling - Other	0	0	0	0		13.00	
14.00 Home Health Aide and Homemaker	0	0	0	0		14.00	
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00	
16.00 Other	0	0	0	0		16.00	
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0		17.00	
18.00 Analgesics	0	0	0	0		18.00	
19.00 Sedatives / Hypnotics	0	0	0	0		19.00	
20.00 Other - Specify	0	0	0	0		20.00	
21.00 Durable Medical Equipment/Oxygen	0	0	0	0		21.00	
22.00 Patient Transportation	0	0	0	0		22.00	
23.00 Imaging Services	0	0	0	0		23.00	
24.00 Labs and Diagnostics	0	0	0	0		24.00	
25.00 Medical Supplies	0	0	0	0		25.00	
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0		26.00	
27.00 Radiation Therapy	0	0	0	0		27.00	
28.00 Chemotherapy	0	0	0	0		28.00	
29.00 Other	0	0	0	0		29.00	
30.00 Bereavement Program Costs	0	0	0	0		30.00	
31.00 Volunteer Program Costs	0	0	0	0		31.00	
32.00 Fundraising	0	0	0	0		32.00	
33.00 Other Program Costs	0	0	0	0		33.00	
34.00 Total (sum of lines 1 thru 33) (2)	0	0	0	32,690		34.00	
35.00 Total cost to be allocated	0	0	0	32,602		35.00	
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.997308		36.00	

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 140189

Period: From 07/01/2015

Worksheet K-5

Hospice CCN: 141599

To 06/30/2016

Part III  
Date/Time Prepared:  
11/18/2016 1:05 pm

Cost Center Description		Hospice I			
		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)
		0	1.00	2.00	3.00
ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.274149	0	0 1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.304335	0	0 2.00
3.00	SPEECH PATHOLOGY	68.00	0.275878	0	0 3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.193077	0	0 4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00			5.00
6.00	LABORATORY	60.00	0.279585	0	0 6.00
6.01	BLOOD LABORATORY	60.01			6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.263801	0	0 7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00			8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.217124	0	0 9.00
10.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	5.384618	0	0 10.00
11.00	Totals (sum of lines 1-10)				0 11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 140189

Period: From 07/01/2015

Worksheet K-6

Hospice CCN: 141599

To 06/30/2016

Date/Time Prepared: 11/18/2016 1:05 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				3,330,589	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				20,884	2.00
3.00	Average cost per diem (line 1 divided by line 2)				159.48	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	17,568				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	2,801,745				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		1,775			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		283,077			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	9,892				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	1,577,576				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		677			10.00
11.00	Aggregate NF cost (line 3 times line 10)		107,968			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			1,541		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			245,759		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet L Parts I-III Date/Time Prepared: 11/18/2016 1:05 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,528,420	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		9,377	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)		61.56	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)		1,537,797	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: 140189 Component CCN: 143978	Period: From 07/01/2015 To 06/30/2016	Worksheet M-1 Date/Time Prepared: 11/18/2016 1:05 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	120,154	11,286	131,440	0	131,440	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	110,050	7,093	117,143	0	117,143	9.00
10.00	Subtotal (sum of lines 1 through 9)	230,204	18,379	248,583	0	248,583	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	18,628	18,628	0	18,628	15.00
16.00	Transportation (Health Care Staff)	0	640	640	0	640	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	9,703	9,703	0	9,703	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	28,971	28,971	0	28,971	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	230,204	47,350	277,554	0	277,554	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	70,096	70,096	0	70,096	29.00
30.00	Administrative Costs	45,773	4,743	50,516	0	50,516	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	45,773	74,839	120,612	0	120,612	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	275,977	122,189	398,166	0	398,166	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet M-1
	Component CCN: 143978		Date/Time Prepared: 11/18/2016 1:05 pm
		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	0
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	131,440
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	0
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	117,143
10.00	Subtotal (sum of lines 1 through 9)	0	248,583
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0
15.00	Medical Supplies	0	18,628
16.00	Transportation (Health Care Staff)	0	640
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	9,703
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	28,971
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	277,554
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
<b>FACILITY OVERHEAD</b>			
29.00	Facility Costs	0	70,096
30.00	Administrative Costs	0	50,516
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	120,612
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	398,166

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2015 To 06/30/2016	Worksheet M-1 Date/Time Prepared: 11/18/2016 1:05 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) II Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1.00	Physician	111,414	11,139	122,553	0	122,553	1.00
2.00	Physician Assistant	142,728	10,449	153,177	0	153,177	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	0	0	0	0	0	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	99,787	7,150	106,937	0	106,937	9.00
10.00	Subtotal (sum of lines 1 through 9)	353,929	28,738	382,667	0	382,667	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	35,543	35,543	0	35,543	15.00
16.00	Transportation (Health Care Staff)	0	741	741	0	741	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	22,640	22,640	0	22,640	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	58,924	58,924	0	58,924	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	353,929	87,662	441,591	0	441,591	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	62,202	62,202	0	62,202	29.00
30.00	Administrative Costs	43,078	4,683	47,761	0	47,761	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	43,078	66,885	109,963	0	109,963	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	397,007	154,547	551,554	0	551,554	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet M-1
	Component CCN: 143998	Rural Health Clinic (RHC) II	Date/Time Prepared: 11/18/2016 1:05 pm 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	122,553	1.00
2.00	Physician Assistant	0	153,177	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	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	106,937	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	382,667	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	35,543	15.00
16.00	Transportation (Health Care Staff)	0	741	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	22,640	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	58,924	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	441,591	22.00
<b>COSTS OTHER THAN RHC/FQHC 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	0	62,202	29.00
30.00	Administrative Costs	0	47,761	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	109,963	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	551,554	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS		Provider CCN: 140189 Component CCN: 143435		Period: From 07/01/2015 To 06/30/2016		Worksheet M-1 Date/Time Prepared: 11/18/2016 1:05 pm	
				Rural Health Clinic (RHC) III		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1.00	Physician	233,002	19,798	252,800	0	252,800	1.00
2.00	Physician Assistant	264,278	11,367	275,645	0	275,645	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	0	0	0	0	0	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	128,734	8,244	136,978	0	136,978	9.00
10.00	Subtotal (sum of lines 1 through 9)	626,014	39,409	665,423	0	665,423	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	29,511	29,511	0	29,511	15.00
16.00	Transportation (Health Care Staff)	0	1,709	1,709	0	1,709	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	22,640	22,640	0	22,640	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	53,860	53,860	0	53,860	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	626,014	93,269	719,283	0	719,283	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	40,166	40,166	0	40,166	29.00
30.00	Administrative Costs	48,480	4,632	53,112	0	53,112	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	48,480	44,798	93,278	0	93,278	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	674,494	138,067	812,561	0	812,561	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet M-1
	Component CCN: 143435		Date/Time Prepared: 11/18/2016 1:05 pm
		Rural Health Clinic (RHC) III	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	252,800
2.00	Physician Assistant	0	275,645
3.00	Nurse Practitioner	0	0
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	0
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	136,978
10.00	Subtotal (sum of lines 1 through 9)	0	665,423
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0
15.00	Medical Supplies	0	29,511
16.00	Transportation (Health Care Staff)	0	1,709
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	22,640
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	53,860
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	719,283
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
<b>FACILITY OVERHEAD</b>			
29.00	Facility Costs	0	40,166
30.00	Administrative Costs	0	53,112
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	93,278
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	812,561

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140189 Component CCN: 148541	Period: From 07/01/2015 To 06/30/2016	Worksheet M-1 Date/Time Prepared: 11/18/2016 1:05 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) IV Reclassifications	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	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	221,512	29,734	251,246	0	251,246	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	78,340	2,841	81,181	0	81,181	9.00
10.00	Subtotal (sum of lines 1 through 9)	299,852	32,575	332,427	0	332,427	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	62,091	62,091	0	62,091	15.00
16.00	Transportation (Health Care Staff)	0	1,361	1,361	0	1,361	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	19,406	19,406	0	19,406	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	82,858	82,858	0	82,858	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	299,852	115,433	415,285	0	415,285	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	56,602	56,602	0	56,602	29.00
30.00	Administrative Costs	142,339	8,413	150,752	0	150,752	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	142,339	65,015	207,354	0	207,354	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	442,191	180,448	622,639	0	622,639	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet M-1
	Component CCN: 148541	Rural Health Clinic (RHC) IV	Date/Time Prepared: 11/18/2016 1:05 pm 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	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	251,246	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	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	81,181	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	332,427	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	62,091	15.00
16.00	Transportation (Health Care Staff)	0	1,361	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	19,406	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	82,858	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	415,285	22.00
<b>COSTS OTHER THAN RHC/FQHC 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	0	56,602	29.00
30.00	Administrative Costs	0	150,752	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	207,354	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	622,639	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140189 Component CCN: 148555	Period: From 07/01/2015 To 06/30/2016	Worksheet M-1 Date/Time Prepared: 11/18/2016 1:05 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) V Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1.00	Physician	545,518	33,741	579,259	0	579,259	1.00
2.00	Physician Assistant	73,932	4,634	78,566	0	78,566	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	0	0	0	0	0	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	76,136	5,822	81,958	0	81,958	9.00
10.00	Subtotal (sum of lines 1 through 9)	695,586	44,197	739,783	0	739,783	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	55,574	55,574	0	55,574	15.00
16.00	Transportation (Health Care Staff)	0	376	376	0	376	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	20,183	20,183	0	20,183	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	76,133	76,133	0	76,133	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	695,586	120,330	815,916	0	815,916	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	54,559	54,559	0	54,559	29.00
30.00	Administrative Costs	114,048	50,377	164,425	0	164,425	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	114,048	104,936	218,984	0	218,984	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	809,634	225,266	1,034,900	0	1,034,900	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet M-1
	Component CCN: 148555		Date/Time Prepared: 11/18/2016 1:05 pm
		Rural Health Clinic (RHC) V	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	579,259	1.00
2.00	Physician Assistant	0	78,566	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	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	81,958	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	739,783	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	55,574	15.00
16.00	Transportation (Health Care Staff)	0	376	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	20,183	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	76,133	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	815,916	22.00
<b>COSTS OTHER THAN RHC/FQHC 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	0	54,559	29.00
30.00	Administrative Costs	0	164,425	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	218,984	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,034,900	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2015	Worksheet M-2
		Component CCN: 143978	To 06/30/2016	Date/Time Prepared: 11/18/2016 1:05 pm
			Rural Health Clinic (RHC) I	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>VISITS AND PRODUCTIVITY</b>						
<b>Positions</b>						
1.00	Physician	0.00	0	0	0	1.00
2.00	Physician Assistant	0.00	0	0	0	2.00
3.00	Nurse Practitioner	1.00	2,655	2,100	2,100	3.00
4.00	Subtotal (sum of lines 1 through 3)	1.00	2,655		2,100	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 (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.00	2,655			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)	277,554	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)	277,554	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)	120,612	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	532,273	15.00
16.00	Total overhead (sum of lines 14 and 15)	652,885	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtotal (see instructions)	652,885	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	652,885	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	930,439	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet M-2
		Component CCN: 143998		Date/Time Prepared: 11/18/2016 1:05 pm
			Rural Health Clinic (RHC) II	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>VI SITS AND PRODUCTI VITY</b>						
<b>Posi tions</b>						
1.00	Physi ci an	0.50	810	2,100	1,050	1.00
2.00	Physi ci an Assistant	1.00	2,995	2,100	2,100	2.00
3.00	Nurse Practitioner	0.00	0	0	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1.50	3,805		3,150	4.00
5.00	Visi ting 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 Nutri tion Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Sel f Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.50	3,805			8.00
9.00	Physi ci an Servi ces Under Agreements		0			9.00
					1.00	

<b>DETERMINATION OF ALLOWABLE COST APPLI CABLE TO RHC/FQHC SERVICES</b>						
10.00	Total costs of heal th care services (from Wkst. M-1, col. 7, line 22)				441,591	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)				441,591	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)				109,963	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				393,335	15.00
16.00	Total overhead (sum of lines 14 and 15)				503,298	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtotal (see instructions)				503,298	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				503,298	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				944,889	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2015	Worksheet M-2
		Component CCN: 143435	To 06/30/2016	Date/Time Prepared: 11/18/2016 1:05 pm
			Rural Health Clinic (RHC) III	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>VI SITS AND PRODUCTI VITY</b>						
<b>Posi tions</b>						
1.00	Physi ci an	1.00	2,277	2,100	2,100	1.00
2.00	Physi ci an Assistant	1.00	4,307	2,100	2,100	2.00
3.00	Nurse Practitioner	0.00	0	0	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2.00	6,584		4,200	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 (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.00	6,584			8.00
9.00	Physi ci an Services Under Agreements		0			9.00
					1.00	

<b>DETERMINATION OF ALLOWABLE COST APPLI CABLE TO RHC/FQHC SERVICES</b>			
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	719,283	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)	719,283	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)	93,278	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	386,971	15.00
16.00	Total overhead (sum of lines 14 and 15)	480,249	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtotal (see instructions)	480,249	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	480,249	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	1,199,532	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet M-2
		Component CCN: 148541		Date/Time Prepared: 11/18/2016 1:05 pm
			Rural Health Clinic (RHC) IV	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>VI SITS AND PRODUCTI VITY</b>						
<b>Posi tions</b>						
1.00	Physi ci an	0.00	0	0	0	1.00
2.00	Physi ci an Assistant	0.00	0	0	0	2.00
3.00	Nurse Practitioner	2.00	6,315	2,100	4,200	3.00
4.00	Subtotal (sum of lines 1 through 3)	2.00	6,315		4,200	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 (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.00	6,315			8.00
9.00	Physi ci an Services Under Agreements		0			9.00
					1.00	

<b>DETERMINATION OF ALLOWABLE COST APPLI CABLE TO RHC/FQHC SERVICES</b>						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				415,285	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)				415,285	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)				207,354	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				339,553	15.00
16.00	Total overhead (sum of lines 14 and 15)				546,907	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtotal (see instructions)				546,907	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				546,907	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				962,192	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2015	Worksheet M-2
		Component CCN: 148555	To 06/30/2016	Date/Time Prepared: 11/18/2016 1:05 pm
			Rural Health Clinic (RHC) V	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>VI SITS AND PRODUCTI VITY</b>						
<b>Posi tions</b>						
1.00	Physi ci an	2.00	7,086	2,100	4,200	1.00
2.00	Physi ci an Assistant	1.00	1,621	2,100	2,100	2.00
3.00	Nurse Practitioner	0.00	0	0	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3.00	8,707		6,300	4.00
5.00	Visi ting 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 Nutri tion Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Sel f Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.00	8,707		8,707	8.00
9.00	Physi ci an Servi ces Under Agreements		0		0	9.00
					1.00	

<b>DETERMINATION OF ALLOWABLE COST APPLI CABLE TO RHC/FQHC SERVICES</b>			
10.00	Total costs of heal th care services (from Wkst. M-1, col. 7, line 22)	815,916	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)	815,916	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)	218,984	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	649,672	15.00
16.00	Total overhead (sum of lines 14 and 15)	868,656	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtotal (see instructions)	868,656	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	868,656	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	1,684,572	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet M-3	
		Component CCN: 143978		Date/Time Prepared: 11/18/2016 1:05 pm	
		Title XVIII	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)			930,439	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			4,244	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			926,195	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,655	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)			2,655	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			348.85	7.00
				<b>Calculation of Limit (1)</b>	
				<b>Prior to January 1</b>	<b>On or After January 1</b>
				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)		80.44	81.32	9.00
<b>CALCULATION OF SETTLEMENT</b>					
10.00	Program covered visits excluding mental health services (from contractor records)		321	302	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		25,821	24,559	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) *			50,380	16.00
16.01	Total program charges (see instructions)(from contractor's records)			82,598	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	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.)			30,822	16.04
16.05	Total program cost (see instructions)			30,822	16.05
17.00	Primary payer amounts			50	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			11,852	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			14,149	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			30,772	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			1,080	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			31,852	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)			31,852	26.00
26.01	Sequestration adjustment (see instructions)			637	26.01
27.00	Interim payments			29,363	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)			1,852	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet M-3	
		Component CCN: 143998		Date/Time Prepared: 11/18/2016 1:05 pm	
		Title XVIII	Rural Health Clinic (RHC) II	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)			944,889	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			7,878	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			937,011	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,805	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)			3,805	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			246.26	7.00
		<b>Calculation of Limit (1)</b>			
				<b>Prior to January 1</b>	<b>On or After January 1</b>
				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)		80.44	81.32	9.00
<b>CALCULATION OF SETTLEMENT</b>					
10.00	Program covered visits excluding mental health services (from contractor records)		405	428	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		32,578	34,805	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) *			67,383	16.00
16.01	Total program charges (see instructions)(from contractor's records)			122,627	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	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.)			40,446	16.04
16.05	Total program cost (see instructions)			40,446	16.05
17.00	Primary payer amounts			41	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			16,826	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			21,160	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			40,405	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			364	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			40,769	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)			40,769	26.00
26.01	Sequestration adjustment (see instructions)			815	26.01
27.00	Interim payments			38,545	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)			1,409	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet M-3	
		Component CCN: 143435		Date/Time Prepared: 11/18/2016 1:05 pm	
		Title XVIII	Rural Health Clinic (RHC) III	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)			1,199,532	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			4,714	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,194,818	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,584	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)			6,584	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			181.47	7.00
		<b>Calculation of Limit (1)</b>			
				<b>Prior to January 1</b>	<b>On or After January 1</b>
				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)		80.44	81.32	9.00
<b>CALCULATION OF SETTLEMENT</b>					
10.00	Program covered visits excluding mental health services (from contractor records)		817	868	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		65,719	70,586	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) *			136,305	16.00
16.01	Total program charges (see instructions)(from contractor's records)			244,766	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	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.)			88,419	16.04
16.05	Total program cost (see instructions)			88,419	16.05
17.00	Primary payer amounts			295	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			25,781	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			43,797	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			88,124	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			515	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			88,639	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)			88,639	26.00
26.01	Sequestration adjustment (see instructions)			1,773	26.01
27.00	Interim payments			84,562	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)			2,304	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet M-3	
		Component CCN: 148541		Date/Time Prepared: 11/18/2016 1:05 pm	
		Title XVII	Rural Health Clinic (RHC) IV	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)			962,192	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			18,621	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			943,571	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,315	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)			6,315	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			149.42	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)	80.44	81.32		9.00
<b>CALCULATION OF SETTLEMENT</b>					
10.00	Program covered visits excluding mental health services (from contractor records)	627	627		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	50,436	50,988		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) *		101,424		16.00
16.01	Total program charges (see instructions)(from contractor's records)		146,681		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0		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.)		68,796		16.04
16.05	Total program cost (see instructions)		68,796		16.05
17.00	Primary payer amounts		1,432		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		15,429		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		26,250		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		67,364		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		659		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		68,023		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)		68,023		26.00
26.01	Sequestration adjustment (see instructions)		1,360		26.01
27.00	Interim payments		66,514		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)		149		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 140189 Component CCN: 143978	Period: From 07/01/2015 To 06/30/2016	Worksheet M-4 Date/Time Prepared: 11/18/2016 1:05 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	248,583	248,583	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	275	991	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	275	991	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	277,554	277,554	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	652,885	652,885	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000991	0.003570	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	647	2,331	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	922	3,322	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	5	82	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	184.40	40.51	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	3	13	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	553	527	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)		4,244	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)		1,080	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 140189  
Component CCN: 143998

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

Worksheet M-4  
Date/Time Prepared:  
11/18/2016 1:05 pm  
Cost

Title XVIII  
Rural Health  
Clinic (RHC) II

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	382,667	382,667	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	990	2,692	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	990	2,692	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	441,591	441,591	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	503,298	503,298	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002242	0.006096	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,128	3,068	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,118	5,760	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	18	223	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	117.67	25.83	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	2	5	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	235	129	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)		7,878	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)		364	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet M-4
		Component CCN: 143435		Date/Time Prepared: 11/18/2016 1:05 pm
		Title XVIII	Rural Health Clinic (RHC) III	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	665,423	665,423	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	605	2,222	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	605	2,222	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	719,283	719,283	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	480,249	480,249	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000841	0.003089	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	404	1,483	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,009	3,705	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	11	184	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	91.73	20.14	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	1	21	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	92	423	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)		4,714	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)		515	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 140189 Component CCN: 148541	Period: From 07/01/2015 To 06/30/2016	Worksheet M-4 Date/Time Prepared: 11/18/2016 1:05 pm
		Title XVIII	Rural Health Clinic (RHC) IV	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	332,427	332,427	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,540	6,497	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,540	6,497	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	415,285	415,285	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	546,907	546,907	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003708	0.015645	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,028	8,556	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,568	15,053	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	28	538	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	127.43	27.98	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	1	19	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	127	532	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)		18,621	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)		659	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet M-4
		Component CCN: 148555		Date/Time Prepared: 11/18/2016 1:05 pm
		Title XVIII	Rural Health Clinic (RHC) V	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	739,783	739,783	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,265	1,631	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,265	1,631	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	815,916	815,916	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	868,656	868,656	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001550	0.001999	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,346	1,736	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,611	3,367	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	23	135	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	113.52	24.94	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	3	4	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	341	100	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)		5,978	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)		441	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet M-5
	Component CCN: 143978		Date/Time Prepared: 11/18/2016 1:05 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		29,363	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			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		29,363	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		1,852	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		31,215	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2015 To 06/30/2016	Worksheet M-5 Date/Time Prepared: 11/18/2016 1:05 pm
		Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		38,545	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			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		38,545	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		1,409	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		39,954	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140189	Period: From 07/01/2015 To 06/30/2016	Worksheet M-5
	Component CCN: 143435		Date/Time Prepared: 11/18/2016 1:05 pm
		Rural Health Clinic (RHC) III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		84,562	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			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		84,562	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		2,304	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		86,866	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140189 Component CCN: 148541	Period: From 07/01/2015 To 06/30/2016	Worksheet M-5 Date/Time Prepared: 11/18/2016 1:05 pm
		Rural Health Clinic (RHC) IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		66,514	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			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		66,514	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		149	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		66,663	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00