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: 150115	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/28/2016 1:03 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/28/2016 Time: 1:03 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSP & HEALTH CARE CTR (150115) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	135,818	122,728	-144,429	0	1.00
2.00	Subprovider - IPF	0	9,062	2		0	2.00
3.00	Subprovider - IRF	0	12,246	49		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	2,096	-9		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		7,706		0	10.00
10.01	RURAL HEALTH CLINIC II	0		11,725		0	10.01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	159,222	142,201	-144,429	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2016 1:02 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 800 WEST 9TH STREET	PO Box:			1.00
2.00	City: JASPER	State: IN	Zip Code: 47546	County: DUBOIS	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	MEMORIAL HOSP & HEALTH CARE CTR	150115	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	MEMORIAL HOSP & HCC (PSYCH)	15S115	99915	4	07/01/1985	N	P	O	4.00
5.00	Subprovider - IRF	MEMORIAL HOSP & HCC (REHAB)	15T115	99915	5	07/01/2005	N	P	O	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	MEMORIAL HOSP & HEALTH CARE CTR	155305	99915		08/04/1987	N	P	O	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	MEMORIAL HOSP & HEALTH CARE CTR	157222	99915		08/28/1991	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FRENCH LICK FAMILY MEDICINE	158507	99915		06/19/2009	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	LOOGOOTEE FAMILY MEDICINE	158508	99915		12/14/2009	N	O	N	15.01
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)	1		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.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	339	709	0	0	1,494	184	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2016 1:02 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	
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	58	0	0	18		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	Y	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				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

		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

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		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	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2016 1:02 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2016 1:02 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		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
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,264,678	0	0	118.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150115	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/28/2016 1:02 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
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2016 1:02 pm

							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.50	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)					10/01/2014	12/29/2015	170.00
							1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)						N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 11/28/2016 1:02 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	11/03/2016	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	11/02/2016	Y	11/02/2016	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 11/28/2016 1:02 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		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.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		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		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		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.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		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.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?			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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BOB	BRANDENBURG	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD,LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(317) 383-3787	BBRANDENBURG@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150115	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/28/2016 1:02 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PARTNER		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: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/28/2016 1:02 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	85	31,110	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)		85	31,110	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	26	9,516	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		111	40,626	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	19	6,954		0	16.00
17.00	SUBPROVIDER - IRF	41.00	8	2,928		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	20	7,320		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	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	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		158				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: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2016 1:02 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,660	199	10,104			1.00
2.00	HMO and other (see instructions)	322	2,203				2.00
3.00	HMO IPF Subprovider	8	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)	4,660	199	10,104			7.00
8.00	INTENSIVE CARE UNIT	2,802	99	4,690			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		41	1,931			13.00
14.00	Total (see instructions)	7,462	339	16,725	0.00	1,247.57	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,651	690	2,943	0.00	34.08	16.00
17.00	SUBPROVIDER - IRF	937	76	1,507	0.00	11.06	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	4,074	216	5,016	0.00	26.29	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	9,578	1,917	16,352	0.00	26.64	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,488	0	3,713	0.00	4.08	26.00
26.01	RURAL HEALTH CLINIC II	1,855	0	6,194	0.00	6.84	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	1,356.56	27.00
28.00	Observation Bed Days		339	2,476			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	184	447			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: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2016 1:02 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,258	258	3,817	1.00
2.00	HMO and other (see instructions)			81	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	2,258	258	3,817	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	175	129	462	16.00
17.00	SUBPROVIDER - IRF	0.00	0	76	9	123	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 11/28/2016 1:02 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	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	94,758,486	0	94,758,486	2,821,617.00	33.58	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		2,494,619	0	2,494,619	24,003.00	103.93	3.00
4.00	Physician-Part A - Administrative		222,716	0	222,716	867.00	256.88	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		8,794,605	0	8,794,605	42,678.00	206.07	5.00
6.00	Non-physician-Part B		1,050,289	0	1,050,289	22,707.00	46.25	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	1,329,370	0	1,329,370	54,680.00	24.31	9.00
10.00	Excluded area salaries (see instructions)		34,523,855	0	34,523,855	873,284.00	39.53	10.00
	OTHER WAGES & RELATED COSTS							
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		119,750	0	119,750	1,015.00	117.98	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
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		12,235,429	0	12,235,429			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		6,016,456	0	6,016,456			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		173,771	0	173,771			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		264,142	0	264,142			23.00
24.00	Wage-related costs (RHC/FQHC)		118,484	0	118,484			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	682,301	0	682,301	20,490.00	33.30	26.00
27.00	Administrative & General	5.00	8,129,496	0	8,129,496	334,938.00	24.27	27.00
28.00	Administrative & General under contract (see inst.)		448,992	0	448,992	1,862.00	241.13	28.00
29.00	Maintenance & Repairs	6.00	1,733,458	0	1,733,458	72,809.00	23.81	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	232,984	0	232,984	19,047.00	12.23	31.00
32.00	Housekeeping	9.00	1,114,645	0	1,114,645	86,853.00	12.83	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,052,551	-738,565	313,986	20,461.00	15.35	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	738,565	738,565	48,129.00	15.35	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	810,004	0	810,004	25,466.00	31.81	38.00
39.00	Central Services and Supply	14.00	257,926	0	257,926	17,987.00	14.34	39.00
40.00	Pharmacy	15.00	1,910,935	0	1,910,935	50,892.00	37.55	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 11/28/2016 1:02 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	
41.00	Medical Records & Medical Records Library	16.00	1,316,949	0	1,316,949	66,123.00	19.92	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part III Date/Time Prepared: 11/28/2016 1:02 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	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		82,867,965	0	82,867,965	2,734,091.00	30.31	1.00
2.00	Excluded area salaries (see instructions)		35,853,225	0	35,853,225	927,964.00	38.64	2.00
3.00	Subtotal salaries (line 1 minus line 2)		47,014,740	0	47,014,740	1,806,127.00	26.03	3.00
4.00	Subtotal other wages & related costs (see inst.)		119,750	0	119,750	1,015.00	117.98	4.00
5.00	Subtotal wage-related costs (see inst.)		12,235,429	0	12,235,429	0.00	26.02	5.00
6.00	Total (sum of lines 3 thru 5)		59,369,919	0	59,369,919	1,807,142.00	32.85	6.00
7.00	Total overhead cost (see instructions)		17,690,241	0	17,690,241	765,057.00	23.12	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part IV Date/Time Prepared: 11/28/2016 1:02 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,467,358	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	-228,640	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	10,817,847	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	79,371	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	238,773	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	383,178	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
	TAXES		
17.00	FICA-Employers Portion Only	5,721,499	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	32,405	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
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	303,283	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	18,815,074	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part V | Date/Time Prepared: 11/28/2016 1:02 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	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	0	0	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	0	0	8.00
9.00	Hospital-Based NF			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
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 150115 | Component CCN: 157222 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-4 | Date/Time Prepared: 11/28/2016 1:02 pm

Home Health Agency I | PPS

					1.00		
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	5,003	495	1,420	6,918	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	525.00	52.00	149.00	726.00	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	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			50031			20.00
20.01				50036			20.01
20.02				99915			20.02
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	3,566	195	174	85	4,020	21.00
22.00	Skilled Nursing Visit Charges	717,510	38,414	36,917	17,487	810,328	22.00
23.00	Physical Therapy Visits	2,425	48	31	39	2,543	23.00
24.00	Physical Therapy Visit Charges	508,040	10,080	6,500	8,170	532,790	24.00
25.00	Occupational Therapy Visits	961	33	4	22	1,020	25.00
26.00	Occupational Therapy Visit Charges	201,410	6,930	840	4,600	213,780	26.00
27.00	Speech Pathology Visits	52	1	0	1	54	27.00
28.00	Speech Pathology Visit Charges	10,910	210	0	210	11,330	28.00
29.00	Medical Social Service Visits	1	0	0	0	1	29.00
30.00	Medical Social Service Visit Charges	239	0	0	0	239	30.00
31.00	Home Health Aide Visits	1,823	64	5	48	1,940	31.00
32.00	Home Health Aide Visit Charges	163,650	5,760	450	4,272	174,132	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	8,828	341	214	195	9,578	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,601,759	61,394	44,707	34,739	1,742,599	35.00
36.00	Total Number of Episodes (standard/non outlier)	468		72	17	557	36.00
37.00	Total Number of Outlier Episodes		8		0	8	37.00
38.00	Total Non-Routine Medical Supply Charges	60,457	3,002	1,494	275	65,228	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-7 | Date/Time Prepared: 11/28/2016 1:02 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	5	0	5	12.00
13.00		RUB	28	0	28	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	156	0	156	15.00
16.00		RVB	597	0	597	16.00
17.00		RVA	61	0	61	17.00
18.00		RHC	869	0	869	18.00
19.00		RHB	1,391	0	1,391	19.00
20.00		RHA	351	0	351	20.00
21.00		RMC	91	0	91	21.00
22.00		RMB	155	0	155	22.00
23.00		RMA	39	0	39	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	2	0	2	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	12	0	12	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	4	0	4	36.00
37.00		LE2	14	0	14	37.00
38.00		LE1	16	0	16	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	28	0	28	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	18	0	18	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	28	0	28	47.00
48.00		CD1	12	0	12	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	43	0	43	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	28	0	28	52.00
53.00		CA2	10	0	10	53.00
54.00		CA1	74	0	74	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-7 | Date/Time Prepared: 11/28/2016 1:02 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	14	0	14	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	22	0	22	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	6	0	6	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		4,074	0	4,074	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99915	99915	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	1,435,705			207.00

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

Provider CCN: 150115 Component CCN: 158507 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-8 | Date/Time Prepared: 11/28/2016 1:02 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	522 SOUTH MAPLE STREET	1.00
		City	State	ZIP Code
		1.00	2.00	3.00
2.00	City, State, ZIP Code, County	FRENCH LICK	IN	47432	2.00
				1.00
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
			Grant Award	Date
			1.00	2.00	
	Source of Federal Funds				
4.00	Community Health Center (Section 330(d), PHS Act)		0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)		0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		0		6.00
7.00	Appalachian Regional Commission		0		7.00
8.00	Look-Alikes		0		8.00
9.00	OTHER (SPECIFY)		0		9.00
			1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	07:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00

				Provider name	CCN number	
				1.00	2.00	
14.00	Provider name, CCN number					14.00

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	16:00	08:00	12:00	07:00	16:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 150115 Component CCN: 158507	Period: From 07/01/2015 To 06/30/2016	Worksheet S-8 Date/Time Prepared: 11/28/2016 1:02 pm
		Rural Health Clinic (RHC) I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	06:00	15:00				11.00

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

Provider CCN: 150115 Component CCN: 158508 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-8 | Date/Time Prepared: 11/28/2016 1:02 pm

		Rural Health Clinic (RHC) II	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	105 COOPER STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	LOOGOOTEE	IN	47553	2.00

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

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

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	18:00	08:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number			14.00

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	18:00	08:00	18:00	08:00	18:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 150115 Component CCN: 158508	Period: From 07/01/2015 To 06/30/2016	Worksheet S-8 Date/Time Prepared: 11/28/2016 1:02 pm
		Rural Health Clinic (RHC) II	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	12:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-10 | Date/Time Prepared: 11/28/2016 1:02 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.342177	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,285,966	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	41,700,416	6.00
7.00	Medicaid cost (line 1 times line 6)	14,268,923	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)	6,982,957	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	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)	6,982,957	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	3,216,273	0	3,216,273	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,100,535	0	1,100,535	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,100,535	0	1,100,535	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?		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)	9,938,896	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	365,618	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	9,573,278	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	3,275,756	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,376,291	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	11,359,248	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/28/2016 1:02 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		7,831,353	7,831,353	0	7,831,353	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		9,072,038	9,072,038	0	9,072,038	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	682,301	19,547,603	20,229,904	0	20,229,904	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,129,496	16,239,087	24,368,583	-13	24,368,570	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,733,458	6,045,312	7,778,770	0	7,778,770	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	232,984	201,120	434,104	0	434,104	8.00
9.00	00900	HOUSEKEEPING	1,114,645	348,720	1,463,365	0	1,463,365	9.00
10.00	01000	DIETARY	1,052,551	725,848	1,778,399	-1,275,446	502,953	10.00
11.00	01100	CAFETERIA	0	0	0	1,247,885	1,247,885	11.00
13.00	01300	NURSING ADMINISTRATION	810,004	129,191	939,195	-869	938,326	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	257,926	197,749	455,675	-140,386	315,289	14.00
15.00	01500	PHARMACY	1,910,935	11,378,855	13,289,790	0	13,289,790	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,316,949	286,214	1,603,163	0	1,603,163	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,045,096	626,367	6,671,463	-2,096,630	4,574,833	30.00
31.00	03100	INTENSIVE CARE UNIT	2,654,787	359,683	3,014,470	-30,182	2,984,288	31.00
40.00	04000	SUBPROVIDER - IPF	2,078,915	283,273	2,362,188	-2,583	2,359,605	40.00
41.00	04100	SUBPROVIDER - IRF	620,749	160,904	781,653	-2,783	778,870	41.00
43.00	04300	NURSERY	0	0	0	601,146	601,146	43.00
44.00	04400	SKILLED NURSING FACILITY	1,329,370	68,890	1,398,260	-7,289	1,390,971	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,868,617	10,773,307	15,641,924	-2,601,082	13,040,842	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,202,294	1,202,294	52.00
53.00	05300	ANESTHESIOLOGY	3,716,995	715,649	4,432,644	-343,907	4,088,737	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,410,418	999,943	6,410,361	-180,714	6,229,647	54.00
56.00	05600	RADIOISOTOPE	211,920	522,269	734,189	-2,924	731,265	56.00
60.00	06000	LABORATORY	2,379,157	4,022,611	6,401,768	0	6,401,768	60.00
65.00	06500	RESPIRATORY THERAPY	1,048,989	453,207	1,502,196	-308,317	1,193,879	65.00
66.00	06600	PHYSICAL THERAPY	2,170,793	297,097	2,467,890	-69,368	2,398,522	66.00
69.00	06900	ELECTROCARDIOLOGY	2,596,932	3,453,955	6,050,887	-3,049,696	3,001,191	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	104,498	7,107	111,605	-2,962	108,643	69.02
69.03	06903	SLEEP LAB	228,798	20,126	248,924	-7,770	241,154	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,757,043	5,757,043	-1,626,385	4,130,658	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,939,105	8,939,105	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	281,631	102,929	384,560	0	384,560	88.00
88.01	08801	RURAL HEALTH CLINIC II	495,482	57,867	553,349	0	553,349	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	389,598	1,059,496	1,449,094	-30,614	1,418,480	90.00
90.01	09001	IMED	363,730	123,231	486,961	0	486,961	90.01
90.02	09002	ONCOLOGY	1,369,047	1,175,351	2,544,398	-31,239	2,513,159	90.02
90.03	09003	OUTPATIENT CENTER	209,523	193,455	402,978	0	402,978	90.03
91.00	09100	EMERGENCY	7,118,001	1,362,763	8,480,764	-93,293	8,387,471	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,813,236	175,298	1,988,534	-30,993	1,957,541	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	1,475,383	294,573	1,769,956	-26,831	1,743,125	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	66,222,914	105,069,484	171,292,398	28,154	171,320,552	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	24,710,087	4,278,797	28,988,884	-28,154	28,960,730	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	659,354	36,043	695,397	0	695,397	192.01
194.00	07950	LODGE	0	462	462	0	462	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	149,967	5,240	155,207	0	155,207	194.02
194.03	07953	MKT/PHY SERVICES	2,250,924	1,985,596	4,236,520	0	4,236,520	194.03
194.04	07954	COMMUNITY EDUCATION	355,952	163,857	519,809	0	519,809	194.04
194.05	07955	VOLUNTEER	158,560	19,600	178,160	0	178,160	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	250,728	644,077	894,805	0	894,805	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
200.00		TOTAL (SUM OF LINES 118-199)	94,758,486	112,203,156	206,961,642	0	206,961,642	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/28/2016 1:02 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-2,762,236	5,069,117		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	32,529	9,104,567		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,915,260	18,314,644		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,878,712	18,489,858		5.00
6.00	00600	MAINTENANCE & REPAIRS	-79,679	7,699,091		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	434,104		8.00
9.00	00900	HOUSEKEEPING	0	1,463,365		9.00
10.00	01000	DIETARY	-38,821	464,132		10.00
11.00	01100	CAFETERIA	-642,302	605,583		11.00
13.00	01300	NURSING ADMINISTRATION	-7,535	930,791		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	315,289		14.00
15.00	01500	PHARMACY	-223,768	13,066,022		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-53,472	1,549,691		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	4,574,833		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,984,288		31.00
40.00	04000	SUBPROVIDER - IPF	-294,269	2,065,336		40.00
41.00	04100	SUBPROVIDER - IRF	-64,570	714,300		41.00
43.00	04300	NURSERY	0	601,146		43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,390,971		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-2,742,068	10,298,774		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,202,294		52.00
53.00	05300	ANESTHESIOLOGY	-3,355,583	733,154		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,308,392	2,921,255		54.00
56.00	05600	RADIOISOTOPE	0	731,265		56.00
60.00	06000	LABORATORY	-150,000	6,251,768		60.00
65.00	06500	RESPIRATORY THERAPY	-2,408	1,191,471		65.00
66.00	06600	PHYSICAL THERAPY	-555	2,397,967		66.00
69.00	06900	ELECTROCARDIOLOGY	-397,470	2,603,721		69.00
69.01	06901	PULMONARY	0	0		69.01
69.02	06902	CARDIOPULMONARY	-9,300	99,343		69.02
69.03	06903	SLEEP LAB	-3,233	237,921		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,130,658		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,939,105		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-22,873	361,687		88.00
88.01	08801	RURAL HEALTH CLINIC II	-5,501	547,848		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	-314,119	1,104,361		90.00
90.01	09001	IMED	-183,019	303,942		90.01
90.02	09002	ONCOLOGY	-3,041	2,510,118		90.02
90.03	09003	OUTPATIENT CENTER	0	402,978		90.03
91.00	09100	EMERGENCY	-4,043,397	4,344,074		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-19,606	1,937,935		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
101.00	10100	HOME HEALTH AGENCY	0	1,743,125		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-26,488,660	144,831,892		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	28,960,730		192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	695,397		192.01
194.00	07950	LODGE	0	462		194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	155,207		194.02
194.03	07953	MKT/PHY SERVICES	0	4,236,520		194.03
194.04	07954	COMMUNITY EDUCATION	0	519,809		194.04
194.05	07955	VOLUNTEER	0	178,160		194.05
194.06	07956	MAB	0	0		194.06
194.08	07958	PUBLIC RELATIONS	0	894,805		194.08
194.09	07959	UNUSED SPACE	0	0		194.09
200.00		TOTAL (SUM OF LINES 118-199)	-26,488,660	180,472,982		200.00

RECLASSIFICATIONS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/28/2016 1:02 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	B - LABOR AND DELIVERY				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1,039,863	162,431	1.00
2.00	NURSERY	43.00	519,931	81,215	2.00
	0		1,559,794	243,646	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	738,565	509,320	1.00
	0		738,565	509,320	
	D - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	8,939,105	1.00
	0		0	8,939,105	
	E - BILLABLE SUPPLES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,312,720	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
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
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
	0		0	7,312,720	
500.00	Grand Total: Increases		2,298,359	17,004,791	500.00

RECLASSIFICATIONS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/28/2016 1:02 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	B - LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	1,559,794	243,646	0		1.00
2.00		0.00	0	0	0		2.00
	0		1,559,794	243,646			
	C - CAFETERIA						
1.00	DIETARY	10.00	738,565	509,320	0		1.00
	0		738,565	509,320			
	D - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	8,939,105	0		1.00
	0		0	8,939,105			
	E - BILLABLE SUPPLES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	13	0		1.00
2.00	DIETARY	10.00	0	27,561	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	869	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	140,386	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	293,190	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	30,182	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	2,583	0		7.00
8.00	SUBPROVIDER - IRF	41.00	0	2,783	0		8.00
9.00	SKILLED NURSING FACILITY	44.00	0	7,289	0		9.00
10.00	OPERATING ROOM	50.00	0	2,601,082	0		10.00
11.00	ANESTHESIOLOGY	53.00	0	343,907	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	180,714	0		12.00
13.00	RADIOISOTOPE	56.00	0	2,924	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	308,317	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	69,368	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	3,049,696	0		16.00
17.00	CARDIOPULMONARY	69.02	0	2,962	0		17.00
18.00	SLEEP LAB	69.03	0	7,770	0		18.00
19.00	CLINIC	90.00	0	30,614	0		19.00
20.00	ONCOLOGY	90.02	0	31,239	0		20.00
21.00	EMERGENCY	91.00	0	93,293	0		21.00
22.00	AMBULANCE SERVICES	95.00	0	30,993	0		22.00
23.00	HOME HEALTH AGENCY	101.00	0	26,831	0		23.00
24.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	28,154	0		24.00
	0		0	7,312,720			
500.00	Grand Total: Decreases		2,298,359	17,004,791			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 11/28/2016 1:02 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	7,585,948	1,579,813	0	1,579,813	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	109,931,972	3,441,900	0	3,441,900	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	95,665,287	11,269,650	0	11,269,650	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	213,183,207	16,291,363	0	16,291,363	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	213,183,207	16,291,363	0	16,291,363	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	9,165,761	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	113,373,872	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	106,934,937	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	229,474,570	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	229,474,570	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 11/28/2016 1:02 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,935,184	1,055,795	2,672,751	167,623	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,072,038	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	13,007,222	1,055,795	2,672,751	167,623	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	7,831,353	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9,072,038	2.00
3.00	Total (sum of lines 1-2)	0	16,903,391	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 11/28/2016 1:02 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	122,539,633	0	122,539,633	0.534001	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	106,934,937	0	106,934,937	0.465999	0	2.00
3.00	Total (sum of lines 1-2)	229,474,570	0	229,474,570	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	3,845,699	1,055,795	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	9,104,567	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,950,266	1,055,795	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	167,623	0	0	5,069,117	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	9,104,567	2.00
3.00	Total (sum of lines 1-2)	0	167,623	0	0	14,173,684	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/28/2016 1:02 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-2,672,751	CAP REL COSTS-BLDG & FIXT	1.00	11	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)	A	-10,791	ADMINISTRATIVE & GENERAL	5.00	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	-10,523,607			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-28,383	ADMINISTRATIVE & GENERAL	5.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,888,939			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-642,302	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	B	-223,768	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-53,472	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	-463	ADMINISTRATIVE & GENERAL	5.00	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	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TELEPHONE DEPRECIATION	A	-89,485	CAP REL COSTS-BLDG & FIXT	1.00	9	33.00
33.01	CRNA	A	-844,129	OPERATING ROOM	50.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/28/2016 1:02 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	MISCELLANEOUS REVENUE	B	-113,985	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ADVERTISING - BENEFITS	A	-28,166	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	MAINTENANCE	B	-30,285	MAINTENANCE & REPAIRS	6.00	0	33.04
33.05	ADVERTISING - FRENCH LICK	A	-774	RURAL HEALTH CLINIC	88.00	0	33.05
33.06	ADVERTISING - LOOGOOTEE	A	-996	RURAL HEALTH CLINIC II	88.01	0	33.06
33.07	ADVERTISING - AMBULANCE	A	-4,396	AMBULANCE SERVICES	95.00	0	33.07
33.08	ADVERTISING - CARING HANDS	A	-1,273	SUBPROVIDER - IPF	40.00	0	33.08
33.09	DIETARY SUPPLEMENTS	B	-36,695	DIETARY	10.00	0	33.09
33.10	CLINICAL ENGINEERING	B	-1,051	MAINTENANCE & REPAIRS	6.00	0	33.10
33.11	MISCELLANEOUS - DIETARY	B	-2,126	DIETARY	10.00	0	33.11
33.12	ADVERTISING - REHAB	A	-500	SUBPROVIDER - IRF	41.00	0	33.12
33.13	MISCELLANEOUS - FINANCE	B	-75,154	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	MISCELLANEOUS - AMBULANCE	B	-15,210	AMBULANCE SERVICES	95.00	0	33.14
33.15	ACCOUNTS PAYABLE DISCOUNT	B	-30,082	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	MISCELLANEOUS - SLEEP LAB	B	-3,233	SLEEP LAB	69.03	0	33.16
33.17	ADVERTISING - ADMIN	B	-800	ADMINISTRATIVE & GENERAL	5.00	10	33.17
33.18	MISCELLANEOUS - CLINCAL	B	-5,347	NURSING ADMINISTRATION	13.00	0	33.18
33.19	MISCELLANEOUS - FRENCH LICK	B	-22,099	RURAL HEALTH CLINIC	88.00	0	33.19
33.20	MISCELLANEOUS - LOOGOOTEE	B	-4,505	RURAL HEALTH CLINIC II	88.01	0	33.20
33.21	MISCELLANEOUS - CARDIAC REHAB	B	-9,300	CARDIOPULMONARY	69.02	0	33.21
33.22	ADVERTISING - NURSING ADMIN	B	-2,188	NURSING ADMINISTRATION	13.00	0	33.22
33.23	HOSPITAL ASSESSMENT FEE	A	-5,174,123	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	CRNA EXPENSE	A	-1,650,490	ANESTHESIOLOGY	53.00	0	33.24
33.25	MISC. PROC. CENTER	B	-2,040	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	BUSINESS OFFICE EXPENSE - PHYSICIAN	A	-434,818	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	AHA & IHA LOBBYING DUES	A	-8,073	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	PHYSICIAN EMPLOYEE BENEFIT OFFSET	A	-1,887,094	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.28
33.29	START-UP COST OFFSET	A	32,529	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.29
33.30	START-UP COST OFFSET	A	51,698	SUBPROVIDER - IPF	40.00	0	33.30
33.33	CABLE TV EXPENSE	A	-48,343	MAINTENANCE & REPAIRS	6.00	0	33.33
33.35	ADVERTISING - AUDIOLOGY	A	1,390	PHYSICAL THERAPY	66.00	0	33.35
33.37	ADVERTISING - ONCOLOGY	A	-3,041	ONCOLOGY	90.02	0	33.37
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-26,488,660				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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/28/2016 1:02 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	AMBULATORY SURGERY CENTER	4,263,956	6,152,895	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	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,263,956	6,152,895	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	C	MHHCC	0.00	MEM HOS OP SURG	40.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 150115	Period: From 07/01/2015 To 06/30/2016	Worksheet A-8-1 Date/Time Prepared: 11/28/2016 1:02 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-1,888,939	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-1,888,939			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	SURGERY CENTER		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 11/28/2016 1:02 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	40.00	SUBPROVIDER - IPF	344,694	344,694	0	0	0	1.00
2.00	41.00	SUBPROVIDER - IRF	130,250	20,250	110,000	142,500	966	2.00
3.00	50.00	OPERATING ROOM	9,000	9,000	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	1,705,093	1,705,093	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	3,308,392	308,392	0	0	0	5.00
6.00	60.00	LABORATORY	150,000	150,000	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	2,408	2,408	0	0	0	7.00
8.00	66.00	PHYSICAL THERAPY	1,945	1,945	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	456,868	234,152	222,716	142,500	867	9.00
10.00	90.00	CLINIC	314,119	314,119	0	0	0	10.00
11.00	90.01	IMED	183,019	183,019	0	0	0	11.00
12.00	91.00	EMERGENCY	4,046,754	4,037,004	9,750	142,500	49	12.00
200.00			10,652,542	7,310,076	342,466		1,882	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	40.00	SUBPROVIDER - IPF	0	0	0	0	0	1.00
2.00	41.00	SUBPROVIDER - IRF	66,180	3,309	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	59,398	2,970	0	0	0	9.00
10.00	90.00	CLINIC	0	0	0	0	0	10.00
11.00	90.01	IMED	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	3,357	168	0	0	0	12.00
200.00			128,935	6,447	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	40.00	SUBPROVIDER - IPF	0	0	0	344,694		1.00
2.00	41.00	SUBPROVIDER - IRF	0	66,180	43,820	64,070		2.00
3.00	50.00	OPERATING ROOM	0	0	0	9,000		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	1,705,093		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	3,308,392		5.00
6.00	60.00	LABORATORY	0	0	0	150,000		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	2,408		7.00
8.00	66.00	PHYSICAL THERAPY	0	0	0	1,945		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	59,398	163,318	397,470		9.00
10.00	90.00	CLINIC	0	0	0	314,119		10.00
11.00	90.01	IMED	0	0	0	183,019		11.00
12.00	91.00	EMERGENCY	0	3,357	6,393	4,043,397		12.00
200.00			0	128,935	213,531	10,523,607		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/28/2016 1:02 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,069,117	5,069,117				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	9,104,567		9,104,567			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	18,314,644	28,669	51,493	18,394,806		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,489,858	1,081,716	1,942,851	1,589,568	23,103,993	5.00
6.00	00600	MAINTENANCE & REPAIRS	7,699,091	368,985	662,729	338,945	9,069,750	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	434,104	18,677	33,546	45,556	531,883	8.00
9.00	00900	HOUSEKEEPING	1,463,365	16,087	28,894	217,948	1,726,294	9.00
10.00	01000	DIETARY	464,132	63,466	113,990	61,394	702,982	10.00
11.00	01100	CAFETERIA	605,583	12,801	22,992	144,412	785,788	11.00
13.00	01300	NURSING ADMINISTRATION	930,791	11,152	20,030	158,381	1,120,354	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	315,289	10,830	19,452	50,433	396,004	14.00
15.00	01500	PHARMACY	13,066,022	35,093	63,029	373,647	13,537,791	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,549,691	29,391	52,789	257,504	1,889,375	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,574,833	329,692	592,155	877,016	6,373,696	30.00
31.00	03100	INTENSIVE CARE UNIT	2,984,288	133,973	240,627	519,093	3,877,981	31.00
40.00	04000	SUBPROVIDER - IPF	2,065,336	105,839	190,095	406,492	2,767,762	40.00
41.00	04100	SUBPROVIDER - IRF	714,300	55,219	99,179	121,376	990,074	41.00
43.00	04300	NURSERY	601,146	41,593	74,705	101,663	819,107	43.00
44.00	04400	SKILLED NURSING FACILITY	1,390,971	72,588	130,375	259,933	1,853,867	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,298,774	360,043	646,668	951,966	12,257,451	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,202,294	76,228	136,913	203,325	1,618,760	52.00
53.00	05300	ANESTHESIOLOGY	733,154	0	0	726,788	1,459,942	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,921,255	133,786	240,292	1,057,904	4,353,237	54.00
56.00	05600	RADIOISOTOPE	731,265	11,436	20,539	41,437	804,677	56.00
60.00	06000	LABORATORY	6,251,768	54,581	98,033	465,199	6,869,581	60.00
65.00	06500	RESPIRATORY THERAPY	1,191,471	19,534	35,085	205,110	1,451,200	65.00
66.00	06600	PHYSICAL THERAPY	2,397,967	80,416	144,434	424,457	3,047,274	66.00
69.00	06900	ELECTROCARDIOLOGY	2,603,721	145,067	260,553	507,781	3,517,122	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	99,343	11,345	20,377	20,433	151,498	69.02
69.03	06903	SLEEP LAB	237,921	16,487	29,611	44,737	328,756	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,130,658	0	0	0	4,130,658	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,939,105	0	0	0	8,939,105	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	361,687	18,632	33,465	55,068	468,852	88.00
88.01	08801	RURAL HEALTH CLINIC II	547,848	42,701	76,695	96,882	764,126	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,104,361	53,390	95,892	76,178	1,329,821	90.00
90.01	09001	IMED	303,942	7,010	12,590	71,120	394,662	90.01
90.02	09002	ONCOLOGY	2,510,118	100,981	181,370	267,691	3,060,160	90.02
90.03	09003	OUTPATIENT CENTER	402,978	0	0	40,968	443,946	90.03
91.00	09100	EMERGENCY	4,344,074	100,414	180,352	1,391,790	6,016,630	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,937,935	18,535	33,291	354,544	2,344,305	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	1,743,125	16,615	29,843	288,483	2,078,066	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	144,831,892	3,682,972	6,614,934	12,815,222	135,376,530	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,593	17,230	0	26,823	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,960,730	752,627	1,351,783	4,831,584	35,896,724	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	695,397	24,720	44,399	128,924	893,440	192.01
194.00	07950	LODGE	462	278,287	499,827	0	778,576	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	155,207	4,948	8,887	29,323	198,365	194.02
194.03	07953	MKT/PHY SERVICES	4,236,520	60,483	108,632	440,125	4,845,760	194.03
194.04	07954	COMMUNITY EDUCATION	519,809	56,282	101,088	69,600	746,779	194.04
194.05	07955	VOLUNTEER	178,160	6,282	11,282	31,003	226,727	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	894,805	12,576	22,587	49,025	978,993	194.08
194.09	07959	UNUSED SPACE	0	180,347	323,918	0	504,265	194.09
200.00		Cross Foot Adjustments					0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/28/2016 1:02 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	2.00	4.00	4A	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	180,472,982	5,069,117	9,104,567	18,394,806	180,472,982	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/28/2016 1:02 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
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	23,103,993					5.00
6.00	00600	MAINTENANCE & REPAIRS	1,331,566	10,401,316				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	78,088	54,117	664,088			8.00
9.00	00900	HOUSEKEEPING	253,444	46,612	6,693	2,033,043		9.00
10.00	01000	DIETARY	103,208	183,892	0	36,295	1,026,377	10.00
11.00	01100	CAFETERIA	115,365	37,092	0	7,321	0	11.00
13.00	01300	NURSING ADMINISTRATION	164,484	32,313	0	6,378	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	58,139	31,380	36,764	6,193	0	14.00
15.00	01500	PHARMACY	1,987,537	101,681	0	20,069	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	277,387	85,161	0	16,808	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	935,748	955,285	167,689	188,546	395,957	30.00
31.00	03100	INTENSIVE CARE UNIT	569,342	388,188	54,946	76,617	183,792	31.00
40.00	04000	SUBPROVIDER - IPF	406,346	306,668	22,129	60,528	115,331	40.00
41.00	04100	SUBPROVIDER - IRF	145,357	159,998	14,029	31,579	59,057	41.00
43.00	04300	NURSERY	120,256	120,517	4,208	23,787	75,672	43.00
44.00	04400	SKILLED NURSING FACILITY	272,174	210,325	37,575	41,512	196,568	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,799,565	1,043,227	120,118	205,903	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	237,657	220,872	0	43,594	0	52.00
53.00	05300	ANESTHESIOLOGY	214,340	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	639,116	387,647	62,749	76,510	0	54.00
56.00	05600	RADIOISOTOPE	118,138	33,135	0	6,540	0	56.00
60.00	06000	LABORATORY	1,008,551	158,150	2,147	31,214	0	60.00
65.00	06500	RESPIRATORY THERAPY	213,056	56,600	0	11,171	0	65.00
66.00	06600	PHYSICAL THERAPY	447,382	233,006	12,466	45,989	0	66.00
69.00	06900	ELECTROCARDIOLOGY	516,363	420,333	34,306	82,962	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	22,242	32,873	0	6,488	0	69.02
69.03	06903	SLEEP LAB	48,266	47,770	0	9,428	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	606,438	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,312,386	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	68,834	53,986	0	10,655	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	112,184	123,727	0	24,420	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	195,236	154,697	0	30,533	0	90.00
90.01	09001	IMED	57,942	20,310	0	4,009	0	90.01
90.02	09002	ONCOLOGY	449,274	292,593	8,449	57,749	0	90.02
90.03	09003	OUTPATIENT CENTER	65,177	0	0	0	0	90.03
91.00	09100	EMERGENCY	883,326	290,950	77,811	57,425	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	344,177	53,706	0	10,600	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	305,089	48,143	0	9,502	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,483,180	6,384,954	662,079	1,240,325	1,026,377	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,938	27,796	0	5,486	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,270,163	2,180,741	1,369	430,419	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	131,170	71,627	0	14,137	0	192.01
194.00	07950	LODGE	114,306	806,338	0	159,148	0	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	29,123	14,337	0	2,830	0	194.02
194.03	07953	MKT/PHY SERVICES	711,425	175,249	0	34,589	0	194.03
194.04	07954	COMMUNITY EDUCATION	109,638	163,078	0	32,187	0	194.04
194.05	07955	VOLUNTEER	33,287	18,201	0	3,592	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	143,730	36,439	640	7,192	0	194.08
194.09	07959	UNUSED SPACE	74,033	522,556	0	103,138	0	194.09
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)	23,103,993	10,401,316	664,088	2,033,043	1,026,377	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/28/2016 1:02 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	945,566					11.00
13.00	01300	NURSING ADMINISTRATION	10,852	1,334,381				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,665	0	536,145			14.00
15.00	01500	PHARMACY	21,687	0	0	15,668,765		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,178	0	0	0	2,296,909	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	74,948	481,907	1,593	0	76,737	30.00
31.00	03100	INTENSIVE CARE UNIT	42,839	275,450	1,667	0	47,055	31.00
40.00	04000	SUBPROVIDER - IPF	30,204	194,210	598	0	21,628	40.00
41.00	04100	SUBPROVIDER - IRF	9,800	63,013	209	0	10,239	41.00
43.00	04300	NURSERY	7,328	47,121	0	0	9,884	43.00
44.00	04400	SKILLED NURSING FACILITY	23,302	0	700	0	9,176	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	60,769	0	3,939	0	385,210	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,657	94,242	0	0	20,772	52.00
53.00	05300	ANESTHESIOLOGY	13,903	0	30	0	16,171	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,615	0	27	0	283,026	54.00
56.00	05600	RADIOISOTOPE	2,207	0	25	0	52,131	56.00
60.00	06000	LABORATORY	46,127	0	0	0	206,077	60.00
65.00	06500	RESPIRATORY THERAPY	18,505	0	444	0	36,031	65.00
66.00	06600	PHYSICAL THERAPY	31,274	0	829	0	48,958	66.00
69.00	06900	ELECTROCARDIOLOGY	26,226	0	482	0	164,524	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	1,730	0	30	0	4,388	69.02
69.03	06903	SLEEP LAB	4,333	0	47	0	9,405	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	234,665	0	59,858	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	286,849	0	91,533	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,668,765	450,528	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,617	0	0	0	5,401	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,060	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	6,557	0	217	0	19,878	90.00
90.01	09001	IMED	5,118	32,908	0	0	3,233	90.01
90.02	09002	ONCOLOGY	22,633	145,530	702	0	57,405	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	4,146	90.03
91.00	09100	EMERGENCY	51,293	0	1,277	0	158,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	37,800	0	490	0	25,730	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	23,610	0	705	0	14,858	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	674,837	1,334,381	535,525	15,668,765	2,292,264	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	209,252	0	620	0	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	4,645	192.01
194.00	07950	LODGE	4	0	0	0	0	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	2,627	0	0	0	0	194.02
194.03	07953	MKT/PHY SERVICES	43,218	0	0	0	0	194.03
194.04	07954	COMMUNITY EDUCATION	9,298	0	0	0	0	194.04
194.05	07955	VOLUNTEER	1,922	0	0	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	4,408	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
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)	945,566	1,334,381	536,145	15,668,765	2,296,909	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/28/2016 1:02 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
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
6.00	00600	MAINTENANCE & REPAIRS					6.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	9,652,106	0	9,652,106		30.00
31.00	03100	INTENSIVE CARE UNIT	5,517,877	0	5,517,877		31.00
40.00	04000	SUBPROVIDER - IPF	3,925,404	0	3,925,404		40.00
41.00	04100	SUBPROVIDER - IRF	1,483,355	0	1,483,355		41.00
43.00	04300	NURSERY	1,227,880	0	1,227,880		43.00
44.00	04400	SKILLED NURSING FACILITY	2,645,199	0	2,645,199		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	15,876,182	0	15,876,182		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,250,554	0	2,250,554		52.00
53.00	05300	ANESTHESIOLOGY	1,704,386	0	1,704,386		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,843,927	0	5,843,927		54.00
56.00	05600	RADIOISOTOPE	1,016,853	0	1,016,853		56.00
60.00	06000	LABORATORY	8,321,847	0	8,321,847		60.00
65.00	06500	RESPIRATORY THERAPY	1,787,007	0	1,787,007		65.00
66.00	06600	PHYSICAL THERAPY	3,867,178	0	3,867,178		66.00
69.00	06900	ELECTROCARDIOLOGY	4,762,318	0	4,762,318		69.00
69.01	06901	PULMONARY	0	0	0		69.01
69.02	06902	CARDIOPULMONARY	219,249	0	219,249		69.02
69.03	06903	SLEEP LAB	448,005	0	448,005		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,031,619	0	5,031,619		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,629,873	0	10,629,873		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,119,293	0	16,119,293		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	611,345	0	611,345		88.00
88.01	08801	RURAL HEALTH CLINIC II	1,030,517	0	1,030,517		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	1,736,939	0	1,736,939		90.00
90.01	09001	IMED	518,182	0	518,182		90.01
90.02	09002	ONCOLOGY	4,094,495	0	4,094,495		90.02
90.03	09003	OUTPATIENT CENTER	513,269	0	513,269		90.03
91.00	09100	EMERGENCY	7,536,994	0	7,536,994		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	2,816,808	0	2,816,808		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
101.00	10100	HOME HEALTH AGENCY	2,479,973	0	2,479,973		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	123,668,634	0	123,668,634		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	64,043	0	64,043		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	43,989,288	0	43,989,288		192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,115,019	0	1,115,019		192.01
194.00	07950	LODGE	1,858,372	0	1,858,372		194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	247,282	0	247,282		194.02
194.03	07953	MKT/PHY SERVICES	5,810,241	0	5,810,241		194.03
194.04	07954	COMMUNITY EDUCATION	1,060,980	0	1,060,980		194.04
194.05	07955	VOLUNTEER	283,729	0	283,729		194.05
194.06	07956	MAB	0	0	0		194.06
194.08	07958	PUBLIC RELATIONS	1,171,402	0	1,171,402		194.08
194.09	07959	UNUSED SPACE	1,203,992	0	1,203,992		194.09
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)	180,472,982	0	180,472,982		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/28/2016 1:02 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
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	28,669	51,493	80,162	80,162	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,081,716	1,942,851	3,024,567	6,926	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	368,985	662,729	1,031,714	1,477	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,677	33,546	52,223	199	8.00
9.00	00900	HOUSEKEEPING	0	16,087	28,894	44,981	950	9.00
10.00	01000	DIETARY	0	63,466	113,990	177,456	268	10.00
11.00	01100	CAFETERIA	0	12,801	22,992	35,793	629	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,152	20,030	31,182	690	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,830	19,452	30,282	220	14.00
15.00	01500	PHARMACY	0	35,093	63,029	98,122	1,628	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,391	52,789	82,180	1,122	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	329,692	592,155	921,847	3,821	30.00
31.00	03100	INTENSIVE CARE UNIT	0	133,973	240,627	374,600	2,262	31.00
40.00	04000	SUBPROVIDER - IPF	0	105,839	190,095	295,934	1,771	40.00
41.00	04100	SUBPROVIDER - IRF	0	55,219	99,179	154,398	529	41.00
43.00	04300	NURSERY	0	41,593	74,705	116,298	443	43.00
44.00	04400	SKILLED NURSING FACILITY	0	72,588	130,375	202,963	1,133	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	360,043	646,668	1,006,711	4,148	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	76,228	136,913	213,141	886	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	3,167	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	133,786	240,292	374,078	4,610	54.00
56.00	05600	RADIOISOTOPE	0	11,436	20,539	31,975	181	56.00
60.00	06000	LABORATORY	0	54,581	98,033	152,614	2,027	60.00
65.00	06500	RESPIRATORY THERAPY	0	19,534	35,085	54,619	894	65.00
66.00	06600	PHYSICAL THERAPY	0	80,416	144,434	224,850	1,850	66.00
69.00	06900	ELECTROCARDIOLOGY	0	145,067	260,553	405,620	2,213	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	11,345	20,377	31,722	89	69.02
69.03	06903	SLEEP LAB	0	16,487	29,611	46,098	195	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	18,632	33,465	52,097	240	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	42,701	76,695	119,396	422	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	53,390	95,892	149,282	332	90.00
90.01	09001	IMED	0	7,010	12,590	19,600	310	90.01
90.02	09002	ONCOLOGY	0	100,981	181,370	282,351	1,166	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	179	90.03
91.00	09100	EMERGENCY	0	100,414	180,352	280,766	6,065	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	18,535	33,291	51,826	1,545	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	16,615	29,843	46,458	1,257	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,682,972	6,614,934	10,297,906	55,844	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,593	17,230	26,823	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	752,627	1,351,783	2,104,410	21,058	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	24,720	44,399	69,119	562	192.01
194.00	07950	LODGE	0	278,287	499,827	778,114	0	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	4,948	8,887	13,835	128	194.02
194.03	07953	MKT/PHY SERVICES	0	60,483	108,632	169,115	1,918	194.03
194.04	07954	COMMUNITY EDUCATION	0	56,282	101,088	157,370	303	194.04
194.05	07955	VOLUNTEER	0	6,282	11,282	17,564	135	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	0	12,576	22,587	35,163	214	194.08
194.09	07959	UNUSED SPACE	0	180,347	323,918	504,265	0	194.09
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/28/2016 1:02 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118-201)	0	5,069,117	9,104,567	14,173,684	80,162	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/28/2016 1:02 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
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	3,031,493					5.00
6.00	00600	MAINTENANCE & REPAIRS	174,720	1,207,911				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,246	6,285	68,953			8.00
9.00	00900	HOUSEKEEPING	33,255	5,413	695	85,294		9.00
10.00	01000	DIETARY	13,542	21,356	0	1,523	214,145	10.00
11.00	01100	CAFETERIA	15,137	4,308	0	307	0	11.00
13.00	01300	NURSING ADMINISTRATION	21,582	3,753	0	268	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,629	3,644	3,817	260	0	14.00
15.00	01500	PHARMACY	260,792	11,808	0	842	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,397	9,890	0	705	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	122,783	110,938	17,413	7,910	82,613	30.00
31.00	03100	INTENSIVE CARE UNIT	74,705	45,081	5,705	3,214	38,347	31.00
40.00	04000	SUBPROVIDER - IPF	53,318	35,614	2,298	2,539	24,063	40.00
41.00	04100	SUBPROVIDER - IRF	19,073	18,581	1,457	1,325	12,322	41.00
43.00	04300	NURSERY	15,779	13,996	437	998	15,788	43.00
44.00	04400	SKILLED NURSING FACILITY	35,713	24,425	3,901	1,742	41,012	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	236,128	121,151	12,472	8,638	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,184	25,650	0	1,829	0	52.00
53.00	05300	ANESTHESIOLOGY	28,124	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	83,861	45,018	6,515	3,210	0	54.00
56.00	05600	RADIOISOTOPE	15,501	3,848	0	274	0	56.00
60.00	06000	LABORATORY	132,336	18,366	223	1,310	0	60.00
65.00	06500	RESPIRATORY THERAPY	27,956	6,573	0	469	0	65.00
66.00	06600	PHYSICAL THERAPY	58,703	27,059	1,294	1,929	0	66.00
69.00	06900	ELECTROCARDIOLOGY	67,754	48,814	3,562	3,481	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	2,918	3,818	0	272	0	69.02
69.03	06903	SLEEP LAB	6,333	5,548	0	396	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	79,573	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	172,203	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,032	6,269	0	447	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	14,720	14,369	0	1,025	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	25,618	17,965	0	1,281	0	90.00
90.01	09001	IMED	7,603	2,359	0	168	0	90.01
90.02	09002	ONCOLOGY	58,951	33,979	877	2,423	0	90.02
90.03	09003	OUTPATIENT CENTER	8,552	0	0	0	0	90.03
91.00	09100	EMERGENCY	115,904	33,788	8,079	2,409	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	45,161	6,237	0	445	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	40,032	5,591	0	399	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,162,818	741,494	68,745	52,038	214,145	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	517	3,228	0	230	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	691,452	253,245	142	18,056	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	17,211	8,318	0	593	0	192.01
194.00	07950	LODGE	14,998	93,640	0	6,677	0	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	3,821	1,665	0	119	0	194.02
194.03	07953	MKT/PHY SERVICES	93,349	20,352	0	1,451	0	194.03
194.04	07954	COMMUNITY EDUCATION	14,386	18,938	0	1,350	0	194.04
194.05	07955	VOLUNTEER	4,368	2,114	0	151	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	18,859	4,232	66	302	0	194.08
194.09	07959	UNUSED SPACE	9,714	60,685	0	4,327	0	194.09
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)	3,031,493	1,207,911	68,953	85,294	214,145	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/28/2016 1:02 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	56,174					11.00
13.00	01300	NURSING ADMINISTRATION	645	58,120				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	455	0	46,307			14.00
15.00	01500	PHARMACY	1,288	0	0	374,480		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,674	0	0	0	131,968	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,452	20,990	138	0	4,407	30.00
31.00	03100	INTENSIVE CARE UNIT	2,545	11,997	144	0	2,702	31.00
40.00	04000	SUBPROVIDER - IPF	1,794	8,459	52	0	1,242	40.00
41.00	04100	SUBPROVIDER - IRF	582	2,745	18	0	588	41.00
43.00	04300	NURSERY	435	2,052	0	0	568	43.00
44.00	04400	SKILLED NURSING FACILITY	1,384	0	60	0	527	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,610	0	340	0	22,121	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	871	4,105	0	0	1,193	52.00
53.00	05300	ANESTHESIOLOGY	826	0	3	0	929	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,472	0	2	0	16,253	54.00
56.00	05600	RADIOISOTOPE	131	0	2	0	2,994	56.00
60.00	06000	LABORATORY	2,740	0	0	0	11,834	60.00
65.00	06500	RESPIRATORY THERAPY	1,099	0	38	0	2,069	65.00
66.00	06600	PHYSICAL THERAPY	1,858	0	72	0	2,811	66.00
69.00	06900	ELECTROCARDIOLOGY	1,558	0	42	0	9,448	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	103	0	3	0	252	69.02
69.03	06903	SLEEP LAB	257	0	4	0	540	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	20,271	0	3,437	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	24,771	0	5,256	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	374,480	25,939	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	215	0	0	0	310	88.00
88.01	08801	RURAL HEALTH CLINIC II	360	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	390	0	19	0	1,141	90.00
90.01	09001	IMED	304	1,433	0	0	186	90.01
90.02	09002	ONCOLOGY	1,345	6,339	61	0	3,296	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	238	90.03
91.00	09100	EMERGENCY	3,047	0	110	0	9,089	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,246	0	42	0	1,478	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	1,403	0	61	0	853	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	40,089	58,120	46,253	374,480	131,701	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,434	0	54	0	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	267	192.01
194.00	07950	LODGE	0	0	0	0	0	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	156	0	0	0	0	194.02
194.03	07953	MKT/PHY SERVICES	2,567	0	0	0	0	194.03
194.04	07954	COMMUNITY EDUCATION	552	0	0	0	0	194.04
194.05	07955	VOLUNTEER	114	0	0	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	262	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
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)	56,174	58,120	46,307	374,480	131,968	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/28/2016 1:02 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
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
6.00	00600	MAINTENANCE & REPAIRS					6.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,297,312	0	1,297,312		30.00
31.00	03100	INTENSIVE CARE UNIT	561,302	0	561,302		31.00
40.00	04000	SUBPROVIDER - IPF	427,084	0	427,084		40.00
41.00	04100	SUBPROVIDER - IRF	211,618	0	211,618		41.00
43.00	04300	NURSERY	166,794	0	166,794		43.00
44.00	04400	SKILLED NURSING FACILITY	312,860	0	312,860		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,415,319	0	1,415,319		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	278,859	0	278,859		52.00
53.00	05300	ANESTHESIOLOGY	33,049	0	33,049		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	536,019	0	536,019		54.00
56.00	05600	RADIOISOTOPE	54,906	0	54,906		56.00
60.00	06000	LABORATORY	321,450	0	321,450		60.00
65.00	06500	RESPIRATORY THERAPY	93,717	0	93,717		65.00
66.00	06600	PHYSICAL THERAPY	320,426	0	320,426		66.00
69.00	06900	ELECTROCARDIOLOGY	542,492	0	542,492		69.00
69.01	06901	PULMONARY	0	0	0		69.01
69.02	06902	CARDIOPULMONARY	39,177	0	39,177		69.02
69.03	06903	SLEEP LAB	59,371	0	59,371		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	103,281	0	103,281		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	202,230	0	202,230		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	400,419	0	400,419		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	68,610	0	68,610		88.00
88.01	08801	RURAL HEALTH CLINIC II	150,292	0	150,292		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	196,028	0	196,028		90.00
90.01	09001	IMED	31,963	0	31,963		90.01
90.02	09002	ONCOLOGY	390,788	0	390,788		90.02
90.03	09003	OUTPATIENT CENTER	8,969	0	8,969		90.03
91.00	09100	EMERGENCY	459,257	0	459,257		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	108,980	0	108,980		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
101.00	10100	HOME HEALTH AGENCY	96,054	0	96,054		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,888,626	0	8,888,626		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,798	0	30,798		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,100,851	0	3,100,851		192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	96,070	0	96,070		192.01
194.00	07950	LODGE	893,429	0	893,429		194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	19,724	0	19,724		194.02
194.03	07953	MKT/PHY SERVICES	288,752	0	288,752		194.03
194.04	07954	COMMUNITY EDUCATION	192,899	0	192,899		194.04
194.05	07955	VOLUNTEER	24,446	0	24,446		194.05
194.06	07956	MAB	0	0	0		194.06
194.08	07958	PUBLIC RELATIONS	59,098	0	59,098		194.08
194.09	07959	UNUSED SPACE	578,991	0	578,991		194.09
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)	14,173,684	0	14,173,684		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/28/2016 1:02 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	786,816					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		786,816				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,450	4,450	94,076,185			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	167,901	167,901	8,129,496	-23,103,993	157,368,989	5.00
6.00	00600	MAINTENANCE & REPAIRS	57,273	57,273	1,733,458	0	9,069,750	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,899	2,899	232,984	0	531,883	8.00
9.00	00900	HOUSEKEEPING	2,497	2,497	1,114,645	0	1,726,294	9.00
10.00	01000	DIETARY	9,851	9,851	313,986	0	702,982	10.00
11.00	01100	CAFETERIA	1,987	1,987	738,565	0	785,788	11.00
13.00	01300	NURSING ADMINISTRATION	1,731	1,731	810,004	0	1,120,354	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,681	1,681	257,926	0	396,004	14.00
15.00	01500	PHARMACY	5,447	5,447	1,910,935	0	13,537,791	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,562	4,562	1,316,949	0	1,889,375	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,174	51,174	4,485,302	0	6,373,696	30.00
31.00	03100	INTENSIVE CARE UNIT	20,795	20,795	2,654,787	0	3,877,981	31.00
40.00	04000	SUBPROVIDER - IPF	16,428	16,428	2,078,915	0	2,767,762	40.00
41.00	04100	SUBPROVIDER - IRF	8,571	8,571	620,749	0	990,074	41.00
43.00	04300	NURSERY	6,456	6,456	519,931	0	819,107	43.00
44.00	04400	SKILLED NURSING FACILITY	11,267	11,267	1,329,370	0	1,853,867	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	55,885	55,885	4,868,617	0	12,257,451	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,832	11,832	1,039,863	0	1,618,760	52.00
53.00	05300	ANESTHESIOLOGY	0	0	3,716,995	0	1,459,942	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,766	20,766	5,410,418	0	4,353,237	54.00
56.00	05600	RADIOISOTOPE	1,775	1,775	211,920	0	804,677	56.00
60.00	06000	LABORATORY	8,472	8,472	2,379,157	0	6,869,581	60.00
65.00	06500	RESPIRATORY THERAPY	3,032	3,032	1,048,989	0	1,451,200	65.00
66.00	06600	PHYSICAL THERAPY	12,482	12,482	2,170,793	0	3,047,274	66.00
69.00	06900	ELECTROCARDIOLOGY	22,517	22,517	2,596,932	0	3,517,122	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	1,761	1,761	104,498	0	151,498	69.02
69.03	06903	SLEEP LAB	2,559	2,559	228,798	0	328,756	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,130,658	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	8,939,105	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,892	2,892	281,631	0	468,852	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,628	6,628	495,482	0	764,126	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	8,287	8,287	389,598	0	1,329,821	90.00
90.01	09001	IMED	1,088	1,088	363,730	0	394,662	90.01
90.02	09002	ONCOLOGY	15,674	15,674	1,369,047	0	3,060,160	90.02
90.03	09003	OUTPATIENT CENTER	0	0	209,523	0	443,946	90.03
91.00	09100	EMERGENCY	15,586	15,586	7,118,001	0	6,016,630	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,877	2,877	1,813,236	0	2,344,305	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	2,579	2,579	1,475,383	0	2,078,066	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	571,662	571,662	65,540,613	-23,103,993	112,272,537	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,489	1,489	0	0	26,823	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	116,821	116,821	24,710,087	0	35,896,724	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,837	3,837	659,354	0	893,440	192.01
194.00	07950	LODGE	43,195	43,195	0	0	778,576	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	768	768	149,967	0	198,365	194.02
194.03	07953	MKT/PHY SERVICES	9,388	9,388	2,250,924	0	4,845,760	194.03
194.04	07954	COMMUNITY EDUCATION	8,736	8,736	355,952	0	746,779	194.04
194.05	07955	VOLUNTEER	975	975	158,560	0	226,727	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	1,952	1,952	250,728	0	978,993	194.08
194.09	07959	UNUSED SPACE	27,993	27,993	0	0	504,265	194.09
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/28/2016 1:02 pm

	Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	5,069,117	9,104,567	18,394,806		23,103,993	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6.442570	11.571406	0.195531		0.146814	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			80,162		3,031,493	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000852		0.019264	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/28/2016 1:02 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
			6.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
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
6.00	00600	MAINTENANCE & REPAIRS	557,192					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,899	917,257				8.00
9.00	00900	HOUSEKEEPING	2,497	9,244	551,796			9.00
10.00	01000	DIETARY	9,851	0	9,851	26,191		10.00
11.00	01100	CAFETERIA	1,987	0	1,987	0	2,218,880	11.00
13.00	01300	NURSING ADMINISTRATION	1,731	0	1,731	0	25,466	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,681	50,780	1,681	0	17,987	14.00
15.00	01500	PHARMACY	5,447	0	5,447	0	50,892	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,562	0	4,562	0	66,123	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,174	231,616	51,174	10,104	175,874	30.00
31.00	03100	INTENSIVE CARE UNIT	20,795	75,893	20,795	4,690	100,527	31.00
40.00	04000	SUBPROVIDER - IPF	16,428	30,565	16,428	2,943	70,878	40.00
41.00	04100	SUBPROVIDER - IRF	8,571	19,377	8,571	1,507	22,997	41.00
43.00	04300	NURSERY	6,456	5,812	6,456	1,931	17,197	43.00
44.00	04400	SKILLED NURSING FACILITY	11,267	51,900	11,267	5,016	54,680	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	55,885	165,911	55,885	0	142,602	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,832	0	11,832	0	34,394	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	32,624	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,766	86,671	20,766	0	97,655	54.00
56.00	05600	RADIOISOTOPE	1,775	0	1,775	0	5,179	56.00
60.00	06000	LABORATORY	8,472	2,965	8,472	0	108,243	60.00
65.00	06500	RESPIRATORY THERAPY	3,032	0	3,032	0	43,425	65.00
66.00	06600	PHYSICAL THERAPY	12,482	17,219	12,482	0	73,388	66.00
69.00	06900	ELECTROCARDIOLOGY	22,517	47,384	22,517	0	61,543	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	1,761	0	1,761	0	4,059	69.02
69.03	06903	SLEEP LAB	2,559	0	2,559	0	10,167	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,892	0	2,892	0	8,487	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,628	0	6,628	0	14,220	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	8,287	0	8,287	0	15,386	90.00
90.01	09001	IMED	1,088	0	1,088	0	12,010	90.01
90.02	09002	ONCOLOGY	15,674	11,670	15,674	0	53,112	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	15,586	107,475	15,586	0	120,366	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,877	0	2,877	0	88,702	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	2,579	0	2,579	0	55,403	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	342,038	914,482	336,642	26,191	1,583,586	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,489	0	1,489	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	116,821	1,891	116,821	0	491,031	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,837	0	3,837	0	0	192.01
194.00	07950	LODGE	43,195	0	43,195	0	10	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	768	0	768	0	6,165	194.02
194.03	07953	MKT/PHY SERVICES	9,388	0	9,388	0	101,416	194.03
194.04	07954	COMMUNITY EDUCATION	8,736	0	8,736	0	21,818	194.04
194.05	07955	VOLUNTEER	975	0	975	0	4,511	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	1,952	884	1,952	0	10,343	194.08
194.09	07959	UNUSED SPACE	27,993	0	27,993	0	0	194.09
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)	10,401,316	664,088	2,033,043	1,026,377	945,566	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/28/2016 1:02 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
			6.00	8.00	9.00	10.00	11.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	18.667382	0.723993	3.684411	39.188156	0.426146	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,207,911	68,953	85,294	214,145	56,174	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.167854	0.075173	0.154575	8.176282	0.025316	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/28/2016 1:02 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	486,989					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,707,777				14.00
15.00	01500	PHARMACY	0	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	359,375,029		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	175,874	49,628	0	12,007,106		30.00
31.00	03100	INTENSIVE CARE UNIT	100,527	51,945	0	7,362,626		31.00
40.00	04000	SUBPROVIDER - IPF	70,878	18,650	0	3,384,099		40.00
41.00	04100	SUBPROVIDER - IRF	22,997	6,521	0	1,602,071		41.00
43.00	04300	NURSERY	17,197	0	0	1,546,487		43.00
44.00	04400	SKILLED NURSING FACILITY	0	21,822	0	1,435,705		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	122,760	0	60,273,872		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,394	0	0	3,250,169		52.00
53.00	05300	ANESTHESIOLOGY	0	931	0	2,530,342		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	841	0	44,285,117		54.00
56.00	05600	RADIOISOTOPE	0	783	0	8,156,906		56.00
60.00	06000	LABORATORY	0	0	0	32,244,927		60.00
65.00	06500	RESPIRATORY THERAPY	0	13,843	0	5,637,811		65.00
66.00	06600	PHYSICAL THERAPY	0	25,822	0	7,660,479		66.00
69.00	06900	ELECTROCARDIOLOGY	0	15,010	0	25,743,050		69.00
69.01	06901	PULMONARY	0	0	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	923	0	686,624		69.02
69.03	06903	SLEEP LAB	0	1,478	0	1,471,629		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,312,720	0	9,365,920		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,939,105	0	14,322,191		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	70,471,877		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	845,072		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000	CLINIC	0	6,747	0	3,110,287		90.00
90.01	09001	IMED	12,010	0	0	505,833		90.01
90.02	09002	ONCOLOGY	53,112	21,879	0	8,982,133		90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	648,747		90.03
91.00	09100	EMERGENCY	0	39,793	0	24,766,403		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	15,279	0	4,026,003		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96.00
101.00	10100	HOME HEALTH AGENCY	0	21,970	0	2,324,811		101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	486,989	16,688,450	100	358,648,297		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	19,327	0	0		192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	726,732		192.01
194.00	07950	LODGE	0	0	0	0		194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	0	0	0		194.02
194.03	07953	MKT/PHY SERVICES	0	0	0	0		194.03
194.04	07954	COMMUNITY EDUCATION	0	0	0	0		194.04
194.05	07955	VOLUNTEER	0	0	0	0		194.05
194.06	07956	MAB	0	0	0	0		194.06
194.08	07958	PUBLIC RELATIONS	0	0	0	0		194.08
194.09	07959	UNUSED SPACE	0	0	0	0		194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/28/2016 1:02 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)		
			13.00	14.00	15.00	16.00		
202.00		Cost to be allocated (per Wkst. B, Part I)	1,334,381	536,145	15,668,765	2,296,909		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.740064	0.032090	156,687.650000	0.006391		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	58,120	46,307	374,480	131,968		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.119346	0.002772	3,744.800000	0.000367		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/28/2016 1:02 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,652,106		9,652,106	0	9,652,106	30.00
31.00	03100	INTENSIVE CARE UNIT	5,517,877		5,517,877	0	5,517,877	31.00
40.00	04000	SUBPROVIDER - IPF	3,925,404		3,925,404	0	3,925,404	40.00
41.00	04100	SUBPROVIDER - IRF	1,483,355		1,483,355	43,820	1,527,175	41.00
43.00	04300	NURSERY	1,227,880		1,227,880	0	1,227,880	43.00
44.00	04400	SKILLED NURSING FACILITY	2,645,199		2,645,199	0	2,645,199	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,876,182		15,876,182	0	15,876,182	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,250,554		2,250,554	0	2,250,554	52.00
53.00	05300	ANESTHESIOLOGY	1,704,386		1,704,386	0	1,704,386	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,843,927		5,843,927	0	5,843,927	54.00
56.00	05600	RADIOISOTOPE	1,016,853		1,016,853	0	1,016,853	56.00
60.00	06000	LABORATORY	8,321,847		8,321,847	0	8,321,847	60.00
65.00	06500	RESPIRATORY THERAPY	1,787,007	0	1,787,007	0	1,787,007	65.00
66.00	06600	PHYSICAL THERAPY	3,867,178	0	3,867,178	0	3,867,178	66.00
69.00	06900	ELECTROCARDIOLOGY	4,762,318		4,762,318	163,318	4,925,636	69.00
69.01	06901	PULMONARY	0		0	0	0	69.01
69.02	06902	CARDIOPULMONARY	219,249		219,249	0	219,249	69.02
69.03	06903	SLEEP LAB	448,005		448,005	0	448,005	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,031,619		5,031,619	0	5,031,619	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,629,873		10,629,873	0	10,629,873	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,119,293		16,119,293	0	16,119,293	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	611,345		611,345	0	611,345	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,030,517		1,030,517	0	1,030,517	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,736,939		1,736,939	0	1,736,939	90.00
90.01	09001	IMED	518,182		518,182	0	518,182	90.01
90.02	09002	ONCOLOGY	4,094,495		4,094,495	0	4,094,495	90.02
90.03	09003	OUTPATIENT CENTER	513,269		513,269	0	513,269	90.03
91.00	09100	EMERGENCY	7,536,994		7,536,994	6,393	7,543,387	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,899,736		1,899,736		1,899,736	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,816,808		2,816,808	0	2,816,808	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	2,479,973		2,479,973		2,479,973	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	125,568,370	0	125,568,370	213,531	125,781,901	200.00
201.00		Less Observation Beds	1,899,736		1,899,736		1,899,736	201.00
202.00		Total (see instructions)	123,668,634	0	123,668,634	213,531	123,882,165	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/28/2016 1:02 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,007,106		12,007,106			30.00
31.00	03100	INTENSIVE CARE UNIT	7,362,626		7,362,626			31.00
40.00	04000	SUBPROVIDER - IPF	3,384,099		3,384,099			40.00
41.00	04100	SUBPROVIDER - IRF	1,602,071		1,602,071			41.00
43.00	04300	NURSERY	1,546,487		1,546,487			43.00
44.00	04400	SKILLED NURSING FACILITY	1,435,705		1,435,705			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,768,080	52,505,792	60,273,872	0.263401	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,249,956	213	3,250,169	0.692442	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	857,491	1,672,851	2,530,342	0.673579	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,102,849	39,182,268	44,285,117	0.131961	0.000000	54.00
56.00	05600	RADIOISOTOPE	430,729	7,726,177	8,156,906	0.124662	0.000000	56.00
60.00	06000	LABORATORY	7,120,540	25,124,387	32,244,927	0.258082	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,663,955	2,973,856	5,637,811	0.316968	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,215,115	3,445,364	7,660,479	0.504822	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	7,220,546	18,522,504	25,743,050	0.184994	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0.000000	0.000000	69.01
69.02	06902	CARDIOPULMONARY	548	686,076	686,624	0.319315	0.000000	69.02
69.03	06903	SLEEP LAB	5,600	1,466,029	1,471,629	0.304428	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,563,463	5,802,457	9,365,920	0.537226	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,461,320	5,860,871	14,322,191	0.742196	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,821,711	44,650,166	70,471,877	0.228734	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	845,072	845,072			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0			88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	54,157	3,056,130	3,110,287	0.558450	0.000000	90.00
90.01	09001	IMED	0	505,833	505,833	1.024413	0.000000	90.01
90.02	09002	ONCOLOGY	115,778	8,866,355	8,982,133	0.455849	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0	648,747	648,747	0.791170	0.000000	90.03
91.00	09100	EMERGENCY	4,011,452	20,754,951	24,766,403	0.304323	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	964,766	1,804,515	2,769,281	0.686003	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,073,827	2,952,176	4,026,003	0.699654	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	2,324,811	2,324,811			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	110,039,977	251,377,601	361,417,578			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	110,039,977	251,377,601	361,417,578			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.263401	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692442	52.00
53.00	05300	ANESTHESIOLOGY	0.673579	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131961	54.00
56.00	05600	RADIOISOTOPE	0.124662	56.00
60.00	06000	LABORATORY	0.258082	60.00
65.00	06500	RESPIRATORY THERAPY	0.316968	65.00
66.00	06600	PHYSICAL THERAPY	0.504822	66.00
69.00	06900	ELECTROCARDIOLOGY	0.191338	69.00
69.01	06901	PULMONARY	0.000000	69.01
69.02	06902	CARDIOPULMONARY	0.319315	69.02
69.03	06903	SLEEP LAB	0.304428	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.537226	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.742196	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228734	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
90.00	09000	CLINIC	0.558450	90.00
90.01	09001	IMED	1.024413	90.01
90.02	09002	ONCOLOGY	0.455849	90.02
90.03	09003	OUTPATIENT CENTER	0.791170	90.03
91.00	09100	EMERGENCY	0.304581	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.686003	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.699654	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	96.00
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: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/28/2016 1:02 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	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,652,106		9,652,106	0	9,652,106	30.00
31.00	03100	INTENSIVE CARE UNIT	5,517,877		5,517,877	0	5,517,877	31.00
40.00	04000	SUBPROVIDER - IPF	3,925,404		3,925,404	0	3,925,404	40.00
41.00	04100	SUBPROVIDER - IRF	1,483,355		1,483,355	43,820	1,527,175	41.00
43.00	04300	NURSERY	1,227,880		1,227,880	0	1,227,880	43.00
44.00	04400	SKILLED NURSING FACILITY	2,645,199		2,645,199	0	2,645,199	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,876,182		15,876,182	0	15,876,182	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,250,554		2,250,554	0	2,250,554	52.00
53.00	05300	ANESTHESIOLOGY	1,704,386		1,704,386	0	1,704,386	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,843,927		5,843,927	0	5,843,927	54.00
56.00	05600	RADIOISOTOPE	1,016,853		1,016,853	0	1,016,853	56.00
60.00	06000	LABORATORY	8,321,847		8,321,847	0	8,321,847	60.00
65.00	06500	RESPIRATORY THERAPY	1,787,007	0	1,787,007	0	1,787,007	65.00
66.00	06600	PHYSICAL THERAPY	3,867,178	0	3,867,178	0	3,867,178	66.00
69.00	06900	ELECTROCARDIOLOGY	4,762,318		4,762,318	163,318	4,925,636	69.00
69.01	06901	PULMONARY	0		0	0	0	69.01
69.02	06902	CARDIOPULMONARY	219,249		219,249	0	219,249	69.02
69.03	06903	SLEEP LAB	448,005		448,005	0	448,005	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,031,619		5,031,619	0	5,031,619	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,629,873		10,629,873	0	10,629,873	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,119,293		16,119,293	0	16,119,293	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	611,345		611,345	0	611,345	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,030,517		1,030,517	0	1,030,517	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,736,939		1,736,939	0	1,736,939	90.00
90.01	09001	IMED	518,182		518,182	0	518,182	90.01
90.02	09002	ONCOLOGY	4,094,495		4,094,495	0	4,094,495	90.02
90.03	09003	OUTPATIENT CENTER	513,269		513,269	0	513,269	90.03
91.00	09100	EMERGENCY	7,536,994		7,536,994	6,393	7,543,387	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,899,736		1,899,736		1,899,736	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,816,808		2,816,808	0	2,816,808	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	2,479,973		2,479,973		2,479,973	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	125,568,370	0	125,568,370	213,531	125,781,901	200.00
201.00		Less Observation Beds	1,899,736		1,899,736		1,899,736	201.00
202.00		Total (see instructions)	123,668,634	0	123,668,634	213,531	123,882,165	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/28/2016 1:02 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,007,106		12,007,106			30.00
31.00	03100	INTENSIVE CARE UNIT	7,362,626		7,362,626			31.00
40.00	04000	SUBPROVIDER - IPF	3,384,099		3,384,099			40.00
41.00	04100	SUBPROVIDER - IRF	1,602,071		1,602,071			41.00
43.00	04300	NURSERY	1,546,487		1,546,487			43.00
44.00	04400	SKILLED NURSING FACILITY	1,435,705		1,435,705			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,768,080	52,505,792	60,273,872	0.263401	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,249,956	213	3,250,169	0.692442	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	857,491	1,672,851	2,530,342	0.673579	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,102,849	39,182,268	44,285,117	0.131961	0.000000	54.00
56.00	05600	RADIOISOTOPE	430,729	7,726,177	8,156,906	0.124662	0.000000	56.00
60.00	06000	LABORATORY	7,120,540	25,124,387	32,244,927	0.258082	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,663,955	2,973,856	5,637,811	0.316968	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,215,115	3,445,364	7,660,479	0.504822	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	7,220,546	18,522,504	25,743,050	0.184994	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0.000000	0.000000	69.01
69.02	06902	CARDIOPULMONARY	548	686,076	686,624	0.319315	0.000000	69.02
69.03	06903	SLEEP LAB	5,600	1,466,029	1,471,629	0.304428	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,563,463	5,802,457	9,365,920	0.537226	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,461,320	5,860,871	14,322,191	0.742196	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,821,711	44,650,166	70,471,877	0.228734	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	845,072	845,072	0.723424	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0.000000	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	54,157	3,056,130	3,110,287	0.558450	0.000000	90.00
90.01	09001	IMED	0	505,833	505,833	1.024413	0.000000	90.01
90.02	09002	ONCOLOGY	115,778	8,866,355	8,982,133	0.455849	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0	648,747	648,747	0.791170	0.000000	90.03
91.00	09100	EMERGENCY	4,011,452	20,754,951	24,766,403	0.304323	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	964,766	1,804,515	2,769,281	0.686003	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,073,827	2,952,176	4,026,003	0.699654	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	2,324,811	2,324,811			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	110,039,977	251,377,601	361,417,578			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	110,039,977	251,377,601	361,417,578			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/28/2016 1:02 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
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
56.00	05600	RADIOISOTOPE	0.000000		56.00
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
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	PULMONARY	0.000000		69.01
69.02	06902	CARDIOPULMONARY	0.000000		69.02
69.03	06903	SLEEP LAB	0.000000		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
74.00	07400	RENAL DIALYSIS	0.000000		74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	IMED	0.000000		90.01
90.02	09002	ONCOLOGY	0.000000		90.02
90.03	09003	OUTPATIENT CENTER	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part I Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Hospital | PPS

	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	1,297,312	0	1,297,312	12,580	103.12	30.00
31.00	INTENSIVE CARE UNIT	561,302		561,302	4,690	119.68	31.00
40.00	SUBPROVIDER - IPF	427,084	0	427,084	2,943	145.12	40.00
41.00	SUBPROVIDER - IRF	211,618	0	211,618	1,507	140.42	41.00
43.00	NURSERY	166,794		166,794	1,931	86.38	43.00
44.00	SKILLED NURSING FACILITY	312,860		312,860	5,016	62.37	44.00
200.00	Total (lines 30-199)	2,976,970		2,976,970	28,667		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	4,660	480,539	30.00
31.00	INTENSIVE CARE UNIT	2,802	335,343	31.00
40.00	SUBPROVIDER - IPF	1,651	239,593	40.00
41.00	SUBPROVIDER - IRF	937	131,574	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	4,074	254,095	44.00
200.00	Total (lines 30-199)	14,124	1,441,144	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,415,319	60,273,872	0.023481	4,314,852	101,317	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	278,859	3,250,169	0.085798	0	0	52.00
53.00	05300	ANESTHESIOLOGY	33,049	2,530,342	0.013061	264,357	3,453	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	536,019	44,285,117	0.012104	3,106,759	37,604	54.00
56.00	05600	RADIOISOTOPE	54,906	8,156,906	0.006731	276,062	1,858	56.00
60.00	06000	LABORATORY	321,450	32,244,927	0.009969	3,764,653	37,530	60.00
65.00	06500	RESPIRATORY THERAPY	93,717	5,637,811	0.016623	1,359,259	22,595	65.00
66.00	06600	PHYSICAL THERAPY	320,426	7,660,479	0.041828	1,226,409	51,298	66.00
69.00	06900	ELECTROCARDIOLOGY	542,492	25,743,050	0.021073	4,321,007	91,057	69.00
69.01	06901	PULMONARY	0	0	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	39,177	686,624	0.057057	246	14	69.02
69.03	06903	SLEEP LAB	59,371	1,471,629	0.040344	2,509	101	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	103,281	9,365,920	0.011027	1,997,586	22,027	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	202,230	14,322,191	0.014120	5,265,564	74,350	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	400,419	70,471,877	0.005682	12,441,290	70,691	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	68,610	845,072	0.081188	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	150,292	0	0.000000	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	196,028	3,110,287	0.063026	814	51	90.00
90.01	09001	IMED	31,963	505,833	0.063189	0	0	90.01
90.02	09002	ONCOLOGY	390,788	8,982,133	0.043507	7,091	309	90.02
90.03	09003	OUTPATIENT CENTER	8,969	648,747	0.013825	0	0	90.03
91.00	09100	EMERGENCY	459,257	24,766,403	0.018544	2,299,394	42,640	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	255,338	2,769,281	0.092204	900,459	83,026	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50-199)	5,961,960	327,728,670		41,548,311	639,921	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part III Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Hospital | PPS

		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
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	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	12,580	0.00	4,660	0		30.00
31.00	03100	INTENSIVE CARE UNIT	4,690	0.00	2,802	0		31.00
40.00	04000	SUBPROVIDER - IPF	2,943	0.00	1,651	0		40.00
41.00	04100	SUBPROVIDER - IRF	1,507	0.00	937	0		41.00
43.00	04300	NURSERY	1,931	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	5,016	0.00	4,074	0		44.00
200.00		Total (lines 30-199)	28,667		14,124	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Hospital | 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Hospital | 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	60,273,872	0.000000	0.000000	4,314,852	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,250,169	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,530,342	0.000000	0.000000	264,357	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,285,117	0.000000	0.000000	3,106,759	54.00
56.00	05600	RADIOISOTOPE	0	8,156,906	0.000000	0.000000	276,062	56.00
60.00	06000	LABORATORY	0	32,244,927	0.000000	0.000000	3,764,653	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,637,811	0.000000	0.000000	1,359,259	65.00
66.00	06600	PHYSICAL THERAPY	0	7,660,479	0.000000	0.000000	1,226,409	66.00
69.00	06900	ELECTROCARDIOLOGY	0	25,743,050	0.000000	0.000000	4,321,007	69.00
69.01	06901	PULMONARY	0	0	0.000000	0.000000	0	69.01
69.02	06902	CARDIOPULMONARY	0	686,624	0.000000	0.000000	246	69.02
69.03	06903	SLEEP LAB	0	1,471,629	0.000000	0.000000	2,509	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,365,920	0.000000	0.000000	1,997,586	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,322,191	0.000000	0.000000	5,265,564	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	70,471,877	0.000000	0.000000	12,441,290	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	845,072	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0.000000	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	3,110,287	0.000000	0.000000	814	90.00
90.01	09001	IMED	0	505,833	0.000000	0.000000	0	90.01
90.02	09002	ONCOLOGY	0	8,982,133	0.000000	0.000000	7,091	90.02
90.03	09003	OUTPATIENT CENTER	0	648,747	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	24,766,403	0.000000	0.000000	2,299,394	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,769,281	0.000000	0.000000	900,459	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	0	327,728,670			41,548,311	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	11,156,000	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	806,672	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,932,824	0		54.00
56.00	05600	RADIOISOTOPE	0	2,684,485	0		56.00
60.00	06000	LABORATORY	0	3,391,591	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	100,927	0		65.00
66.00	06600	PHYSICAL THERAPY	0	41,177	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	6,416,390	0		69.00
69.01	06901	PULMONARY	0	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	171,307	0		69.02
69.03	06903	SLEEP LAB	0	366,055	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,748,124	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,264,855	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,996,924	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	69,736	0		90.00
90.01	09001	IMED	0	17,437	0		90.01
90.02	09002	ONCOLOGY	0	633,207	0		90.02
90.03	09003	OUTPATIENT CENTER	0	0	0		90.03
91.00	09100	EMERGENCY	0	4,184,481	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,959,556	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00		Total (lines 50-199)	0	70,941,748	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.263401	11,156,000	0	0	2,938,502	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692442	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.673579	806,672	0	0	543,357	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131961	13,932,824	0	0	1,838,589	54.00
56.00	05600	RADIOISOTOPE	0.124662	2,684,485	0	0	334,653	56.00
60.00	06000	LABORATORY	0.258082	3,391,591	580	0	875,309	60.00
65.00	06500	RESPIRATORY THERAPY	0.316968	100,927	0	0	31,991	65.00
66.00	06600	PHYSICAL THERAPY	0.504822	41,177	0	0	20,787	66.00
69.00	06900	ELECTROCARDIOLOGY	0.184994	6,416,390	0	0	1,186,994	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.319315	171,307	0	0	54,701	69.02
69.03	06903	SLEEP LAB	0.304428	366,055	0	0	111,437	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.537226	1,748,124	0	0	939,138	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.742196	2,264,855	0	0	1,680,966	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228734	20,996,924	370	211,972	4,802,710	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.558450	69,736	0	0	38,944	90.00
90.01	09001	IMED	1.024413	17,437	0	0	17,863	90.01
90.02	09002	ONCOLOGY	0.455849	633,207	0	0	288,647	90.02
90.03	09003	OUTPATIENT CENTER	0.791170	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.304323	4,184,481	0	0	1,273,434	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.686003	1,959,556	0	0	1,344,261	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.699654		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		70,941,748	950	211,972	18,322,283	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		70,941,748	950	211,972	18,322,283	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	150	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	PULMONARY	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	0		69.02
69.03	06903	SLEEP LAB	0	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85	48,485		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	IMED	0	0		90.01
90.02	09002	ONCOLOGY	0	0		90.02
90.03	09003	OUTPATIENT CENTER	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	235	48,485		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	235	48,485		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150115 | Component CCN: 15S115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/28/2016 1:02 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,415,319	60,273,872	0.023481	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	278,859	3,250,169	0.085798	0	0	52.00
53.00	05300	ANESTHESIOLOGY	33,049	2,530,342	0.013061	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	536,019	44,285,117	0.012104	76,075	921	54.00
56.00	05600	RADIOISOTOPE	54,906	8,156,906	0.006731	0	0	56.00
60.00	06000	LABORATORY	321,450	32,244,927	0.009969	206,067	2,054	60.00
65.00	06500	RESPIRATORY THERAPY	93,717	5,637,811	0.016623	15,769	262	65.00
66.00	06600	PHYSICAL THERAPY	320,426	7,660,479	0.041828	24,012	1,004	66.00
69.00	06900	ELECTROCARDIOLOGY	542,492	25,743,050	0.021073	16,483	347	69.00
69.01	06901	PULMONARY	0	0	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	39,177	686,624	0.057057	0	0	69.02
69.03	06903	SLEEP LAB	59,371	1,471,629	0.040344	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	103,281	9,365,920	0.011027	5,622	62	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	202,230	14,322,191	0.014120	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	400,419	70,471,877	0.005682	379,734	2,158	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	68,610	845,072	0.081188	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	150,292	0	0.000000	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	196,028	3,110,287	0.063026	0	0	90.00
90.01	09001	IMED	31,963	505,833	0.063189	0	0	90.01
90.02	09002	ONCOLOGY	390,788	8,982,133	0.043507	0	0	90.02
90.03	09003	OUTPATIENT CENTER	8,969	648,747	0.013825	0	0	90.03
91.00	09100	EMERGENCY	459,257	24,766,403	0.018544	161,205	2,989	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,769,281	0.000000	345	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50-199)	5,706,622	327,728,670		885,312	9,797	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150115 | Component CCN: 15S115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/28/2016 1:02 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 150115 | Component CCN: 15S115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/28/2016 1:02 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	60,273,872	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,250,169	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,530,342	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,285,117	0.000000	0.000000	76,075	54.00
56.00	05600	RADIOISOTOPE	0	8,156,906	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	32,244,927	0.000000	0.000000	206,067	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,637,811	0.000000	0.000000	15,769	65.00
66.00	06600	PHYSICAL THERAPY	0	7,660,479	0.000000	0.000000	24,012	66.00
69.00	06900	ELECTROCARDIOLOGY	0	25,743,050	0.000000	0.000000	16,483	69.00
69.01	06901	PULMONARY	0	0	0.000000	0.000000	0	69.01
69.02	06902	CARDIOPULMONARY	0	686,624	0.000000	0.000000	0	69.02
69.03	06903	SLEEP LAB	0	1,471,629	0.000000	0.000000	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,365,920	0.000000	0.000000	5,622	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,322,191	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	70,471,877	0.000000	0.000000	379,734	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	845,072	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0.000000	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	3,110,287	0.000000	0.000000	0	90.00
90.01	09001	IMED	0	505,833	0.000000	0.000000	0	90.01
90.02	09002	ONCOLOGY	0	8,982,133	0.000000	0.000000	0	90.02
90.03	09003	OUTPATIENT CENTER	0	648,747	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	24,766,403	0.000000	0.000000	161,205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,769,281	0.000000	0.000000	345	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	0	327,728,670			885,312	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150115 | Component CCN: 15S115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/28/2016 1:02 pm

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		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	PULMONARY	0	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	0	0		69.02
69.03	06903	SLEEP LAB	0	0	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	50	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	IMED	0	0	0		90.01
90.02	09002	ONCOLOGY	0	0	0		90.02
90.03	09003	OUTPATIENT CENTER	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00		Total (lines 50-199)	0	50	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150115 | Component CCN: 15S115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.263401	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692442	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.673579	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131961	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.124662	0	0	0	0	56.00
60.00	06000	LABORATORY	0.258082	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.316968	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.504822	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.184994	0	0	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.319315	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0.304428	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.537226	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.742196	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228734	50	0	53	11	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.558450	0	0	0	0	90.00
90.01	09001	IMED	1.024413	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.455849	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.791170	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.304323	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.686003	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.699654		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		50	0	53	11	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		50	0	53	11	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150115 | Component CCN: 15S115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	PULMONARY	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	0		69.02
69.03	06903	SLEEP LAB	0	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	IMED	0	0		90.01
90.02	09002	ONCOLOGY	0	0		90.02
90.03	09003	OUTPATIENT CENTER	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	12		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	12		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150115 | Component CCN: 15T115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Subprovider - IRF | 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,415,319	60,273,872	0.023481	1,700	40	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	278,859	3,250,169	0.085798	0	0	52.00
53.00	05300	ANESTHESIOLOGY	33,049	2,530,342	0.013061	15	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	536,019	44,285,117	0.012104	24,249	294	54.00
56.00	05600	RADIOISOTOPE	54,906	8,156,906	0.006731	0	0	56.00
60.00	06000	LABORATORY	321,450	32,244,927	0.009969	67,983	678	60.00
65.00	06500	RESPIRATORY THERAPY	93,717	5,637,811	0.016623	25,405	422	65.00
66.00	06600	PHYSICAL THERAPY	320,426	7,660,479	0.041828	683,982	28,610	66.00
69.00	06900	ELECTROCARDIOLOGY	542,492	25,743,050	0.021073	2,656	56	69.00
69.01	06901	PULMONARY	0	0	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	39,177	686,624	0.057057	0	0	69.02
69.03	06903	SLEEP LAB	59,371	1,471,629	0.040344	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	103,281	9,365,920	0.011027	15,628	172	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	202,230	14,322,191	0.014120	374	5	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	400,419	70,471,877	0.005682	302,567	1,719	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	68,610	845,072	0.081188	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	150,292	0	0.000000	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	196,028	3,110,287	0.063026	0	0	90.00
90.01	09001	IMED	31,963	505,833	0.063189	0	0	90.01
90.02	09002	ONCOLOGY	390,788	8,982,133	0.043507	0	0	90.02
90.03	09003	OUTPATIENT CENTER	8,969	648,747	0.013825	0	0	90.03
91.00	09100	EMERGENCY	459,257	24,766,403	0.018544	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,769,281	0.000000	10,609	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50-199)	5,706,622	327,728,670		1,135,168	31,996	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150115 | Component CCN: 15T115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Subprovider - IRF | 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 150115 | Component CCN: 15T115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Subprovider - IRF | 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	60,273,872	0.000000	0.000000	1,700	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,250,169	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,530,342	0.000000	0.000000	15	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,285,117	0.000000	0.000000	24,249	54.00
56.00	05600	RADIOISOTOPE	0	8,156,906	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	32,244,927	0.000000	0.000000	67,983	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,637,811	0.000000	0.000000	25,405	65.00
66.00	06600	PHYSICAL THERAPY	0	7,660,479	0.000000	0.000000	683,982	66.00
69.00	06900	ELECTROCARDIOLOGY	0	25,743,050	0.000000	0.000000	2,656	69.00
69.01	06901	PULMONARY	0	0	0.000000	0.000000	0	69.01
69.02	06902	CARDIOPULMONARY	0	686,624	0.000000	0.000000	0	69.02
69.03	06903	SLEEP LAB	0	1,471,629	0.000000	0.000000	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,365,920	0.000000	0.000000	15,628	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,322,191	0.000000	0.000000	374	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	70,471,877	0.000000	0.000000	302,567	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	845,072	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0.000000	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	3,110,287	0.000000	0.000000	0	90.00
90.01	09001	IMED	0	505,833	0.000000	0.000000	0	90.01
90.02	09002	ONCOLOGY	0	8,982,133	0.000000	0.000000	0	90.02
90.03	09003	OUTPATIENT CENTER	0	648,747	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	24,766,403	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,769,281	0.000000	0.000000	10,609	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	0	327,728,670			1,135,168	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150115 | Component CCN: 15T115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Subprovider - IRF | 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		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	PULMONARY	0	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	0	0		69.02
69.03	06903	SLEEP LAB	0	0	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	1,250	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	IMED	0	0	0		90.01
90.02	09002	ONCOLOGY	0	0	0		90.02
90.03	09003	OUTPATIENT CENTER	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00		Total (lines 50-199)	0	1,250	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150115 | Component CCN: 15T115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.263401	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692442	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.673579	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131961	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.124662	0	0	0	0	56.00
60.00	06000	LABORATORY	0.258082	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.316968	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.504822	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.184994	0	0	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.319315	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0.304428	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.537226	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.742196	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228734	1,250	0	5,444	286	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.558450	0	0	0	0	90.00
90.01	09001	IMED	1.024413	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.455849	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.791170	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.304323	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.686003	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.699654		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		1,250	0	5,444	286	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		1,250	0	5,444	286	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150115 | Component CCN: 15T115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	PULMONARY	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	0		69.02
69.03	06903	SLEEP LAB	0	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,245		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	IMED	0	0		90.01
90.02	09002	ONCOLOGY	0	0		90.02
90.03	09003	OUTPATIENT CENTER	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	1,245		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	1,245		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150115 | Component CCN: 155305 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 150115 | Component CCN: 155305 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	60,273,872	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,250,169	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,530,342	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,285,117	0.000000	0.000000	18,330	54.00
56.00	05600	RADIOISOTOPE	0	8,156,906	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	32,244,927	0.000000	0.000000	334,712	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,637,811	0.000000	0.000000	115,034	65.00
66.00	06600	PHYSICAL THERAPY	0	7,660,479	0.000000	0.000000	1,114,668	66.00
69.00	06900	ELECTROCARDIOLOGY	0	25,743,050	0.000000	0.000000	5,606	69.00
69.01	06901	PULMONARY	0	0	0.000000	0.000000	0	69.01
69.02	06902	CARDIOPULMONARY	0	686,624	0.000000	0.000000	0	69.02
69.03	06903	SLEEP LAB	0	1,471,629	0.000000	0.000000	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,365,920	0.000000	0.000000	70,517	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,322,191	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	70,471,877	0.000000	0.000000	1,962,621	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	845,072	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0.000000	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	3,110,287	0.000000	0.000000	0	90.00
90.01	09001	IMED	0	505,833	0.000000	0.000000	0	90.01
90.02	09002	ONCOLOGY	0	8,982,133	0.000000	0.000000	0	90.02
90.03	09003	OUTPATIENT CENTER	0	648,747	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	24,766,403	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,769,281	0.000000	0.000000	53,353	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	0	327,728,670			3,674,841	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150115 | Component CCN: 155305 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	PULMONARY	0	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	0	0		69.02
69.03	06903	SLEEP LAB	0	0	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	IMED	0	0	0		90.01
90.02	09002	ONCOLOGY	0	0	0		90.02
90.03	09003	OUTPATIENT CENTER	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150115 | Component CCN: 155305 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.263401	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692442	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.673579	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131961	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.124662	0	0	0	0	56.00
60.00	06000	LABORATORY	0.258082	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.316968	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.504822	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.184994	0	0	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.319315	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0.304428	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.537226	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.742196	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228734	0	0	7,516	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.558450	0	0	0	0	90.00
90.01	09001	IMED	1.024413	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.455849	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.791170	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.304323	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.686003	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.699654		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	0	7,516	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	7,516	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150115 | Component CCN: 155305 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	PULMONARY	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	0		69.02
69.03	06903	SLEEP LAB	0	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,719		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	IMED	0	0		90.01
90.02	09002	ONCOLOGY	0	0		90.02
90.03	09003	OUTPATIENT CENTER	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	1,719		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	1,719		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/28/2016 1:02 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.263401	0	6,984,837	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692442	0	71	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.673579	0	255,068	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131961	0	5,420,258	0	0	54.00
56.00	05600	RADIOISOTOPE	0.124662	0	509,534	0	0	56.00
60.00	06000	LABORATORY	0.258082	0	2,649,301	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.316968	0	233,456	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.504822	0	539,323	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.184994	0	1,701,920	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.319315	0	21,554	0	0	69.02
69.03	06903	SLEEP LAB	0.304428	0	157,550	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.537226	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.742196	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228734	0	2,685,160	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.723424				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.558450	0	227,105	0	0	90.00
90.01	09001	IMED	1.024413	0	853	0	0	90.01
90.02	09002	ONCOLOGY	0.455849	0	1,753,689	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.791170	0	49,590	0	0	90.03
91.00	09100	EMERGENCY	0.304323	0	4,086,788	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.686003	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.699654	0	447,208			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	27,723,265	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	27,723,265	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/28/2016 1:02 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,839,813	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	49	0		52.00
53.00	05300	ANESTHESIOLOGY	171,808	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	715,263	0		54.00
56.00	05600	RADIOISOTOPE	63,520	0		56.00
60.00	06000	LABORATORY	683,737	0		60.00
65.00	06500	RESPIRATORY THERAPY	73,998	0		65.00
66.00	06600	PHYSICAL THERAPY	272,262	0		66.00
69.00	06900	ELECTROCARDIOLOGY	314,845	0		69.00
69.01	06901	PULMONARY	0	0		69.01
69.02	06902	CARDIOPULMONARY	6,883	0		69.02
69.03	06903	SLEEP LAB	47,963	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	614,187	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	126,827	0		90.00
90.01	09001	IMED	874	0		90.01
90.02	09002	ONCOLOGY	799,417	0		90.02
90.03	09003	OUTPATIENT CENTER	39,234	0		90.03
91.00	09100	EMERGENCY	1,243,704	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	312,891			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	7,327,275	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	7,327,275	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,580	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,580	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)	10,104	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)	4,660	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
	SWING BED ADJUSTMENT		
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)	9,652,106	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)	9,652,106	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	9,652,106	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	767.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,575,432	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,575,432	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,517,877	4,690	1,176.52	2,802	3,296,609	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	13,756,890	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	20,628,931	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)	815,882	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	639,921	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,455,803	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	19,173,128	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)	2,476	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	767.26	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,899,736	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Hospital | 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	1,297,312	9,652,106	0.134407	1,899,736	255,338	90.00
91.00	Nursing School cost	0	9,652,106	0.000000	1,899,736	0	91.00
92.00	Allied health cost	0	9,652,106	0.000000	1,899,736	0	92.00
93.00	All other Medical Education	0	9,652,106	0.000000	1,899,736	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115 Component CCN: 15S115	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/28/2016 1:02 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,943	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,943	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)	2,943	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)	1,651	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
	SWING BED ADJUSTMENT		
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)	3,925,404	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)	3,925,404	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,925,404	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,333.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,202,120	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)	2,202,120	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1
Component CCN: 15S115 | Date/Time Prepared: 11/28/2016 1:02 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
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	222,710	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,424,830	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)	239,593	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	9,797	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	249,390	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,175,440	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)	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: 150115 Component CCN: 15S115	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/28/2016 1:02 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	427,084	3,925,404	0.108800	0	0	90.00
91.00	Nursing School cost	0	3,925,404	0.000000	0	0	91.00
92.00	Allied health cost	0	3,925,404	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,925,404	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115 Component CCN: 15T115	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/28/2016 1:02 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,507	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,507	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)	1,507	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)	937	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
	SWING BED ADJUSTMENT		
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)	1,527,175	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)	1,527,175	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,527,175	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,013.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	949,546	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)	949,546	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150115 | Component CCN: 15T115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	460,212	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,409,758	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)	131,574	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	31,996	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	163,570	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,246,188	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)	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: 150115 Component CCN: 15T115	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/28/2016 1:02 pm
	Title XVIII	Subprovider - IRF	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	211,618	1,527,175	0.138568	0	0	90.00
91.00	Nursing School cost	0	1,527,175	0.000000	0	0	91.00
92.00	Allied health cost	0	1,527,175	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,527,175	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/28/2016 1:02 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,016	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,016	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)	5,016	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)	4,074	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
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,645,199	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,645,199	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,645,199	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1
Component CCN: 155305 | Date/Time Prepared: 11/28/2016 1:02 pm
Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,645,199	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	527.35	71.00
72.00	Program routine service cost (line 9 x line 71)	2,148,424	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	2,148,424	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	2,148,424	83.00
84.00	Program inpatient ancillary services (see instructions)	1,212,412	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	3,360,836	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/28/2016 1:02 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Hospital | 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	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		5,144,500		30.00
31.00	03100	INTENSIVE CARE UNIT		4,138,000		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.263401	4,314,852	1,136,536	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692442	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.673579	264,357	178,065	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131961	3,106,759	409,971	54.00
56.00	05600	RADIOISOTOPE	0.124662	276,062	34,414	56.00
60.00	06000	LABORATORY	0.258082	3,764,653	971,589	60.00
65.00	06500	RESPIRATORY THERAPY	0.316968	1,359,259	430,842	65.00
66.00	06600	PHYSICAL THERAPY	0.504822	1,226,409	619,118	66.00
69.00	06900	ELECTROCARDIOLOGY	0.191338	4,321,007	826,773	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.319315	246	79	69.02
69.03	06903	SLEEP LAB	0.304428	2,509	764	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.537226	1,997,586	1,073,155	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.742196	5,265,564	3,908,081	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228734	12,441,290	2,845,746	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.558450	814	455	90.00
90.01	09001	IMED	1.024413	0	0	90.01
90.02	09002	ONCOLOGY	0.455849	7,091	3,232	90.02
90.03	09003	OUTPATIENT CENTER	0.791170	0	0	90.03
91.00	09100	EMERGENCY	0.304581	2,299,394	700,352	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.686003	900,459	617,718	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		41,548,311	13,756,890	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)		41,548,311		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150115 | Component CCN: 15S115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/28/2016 1:02 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	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		1,894,500		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.263401	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692442	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.673579	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131961	76,075	10,039	54.00
56.00	05600	RADIOISOTOPE	0.124662	0	0	56.00
60.00	06000	LABORATORY	0.258082	206,067	53,182	60.00
65.00	06500	RESPIRATORY THERAPY	0.316968	15,769	4,998	65.00
66.00	06600	PHYSICAL THERAPY	0.504822	24,012	12,122	66.00
69.00	06900	ELECTROCARDIOLOGY	0.191338	16,483	3,154	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.319315	0	0	69.02
69.03	06903	SLEEP LAB	0.304428	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.537226	5,622	3,020	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.742196	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228734	379,734	86,858	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.558450	0	0	90.00
90.01	09001	IMED	1.024413	0	0	90.01
90.02	09002	ONCOLOGY	0.455849	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.791170	0	0	90.03
91.00	09100	EMERGENCY	0.304581	161,205	49,100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.686003	345	237	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		885,312	222,710	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		885,312		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150115 | Component CCN: 15T115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Subprovider - IRF | 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	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		983,220		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.263401	1,700	448	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692442	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.673579	15	10	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131961	24,249	3,200	54.00
56.00	05600	RADIOISOTOPE	0.124662	0	0	56.00
60.00	06000	LABORATORY	0.258082	67,983	17,545	60.00
65.00	06500	RESPIRATORY THERAPY	0.316968	25,405	8,053	65.00
66.00	06600	PHYSICAL THERAPY	0.504822	683,982	345,289	66.00
69.00	06900	ELECTROCARDIOLOGY	0.191338	2,656	508	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.319315	0	0	69.02
69.03	06903	SLEEP LAB	0.304428	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.537226	15,628	8,396	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.742196	374	278	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228734	302,567	69,207	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.558450	0	0	90.00
90.01	09001	IMED	1.024413	0	0	90.01
90.02	09002	ONCOLOGY	0.455849	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.791170	0	0	90.03
91.00	09100	EMERGENCY	0.304581	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.686003	10,609	7,278	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		1,135,168	460,212	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,135,168		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150115 | Component CCN: 155305 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.263401	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692442	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.673579	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131961	18,330	2,419	54.00
56.00	05600	RADIOISOTOPE	0.124662	0	0	56.00
60.00	06000	LABORATORY	0.258082	334,712	86,383	60.00
65.00	06500	RESPIRATORY THERAPY	0.316968	115,034	36,462	65.00
66.00	06600	PHYSICAL THERAPY	0.504822	1,114,668	562,709	66.00
69.00	06900	ELECTROCARDIOLOGY	0.184994	5,606	1,037	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.319315	0	0	69.02
69.03	06903	SLEEP LAB	0.304428	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.537226	70,517	37,884	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.742196	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228734	1,962,621	448,918	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.558450	0	0	90.00
90.01	09001	IMED	1.024413	0	0	90.01
90.02	09002	ONCOLOGY	0.455849	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.791170	0	0	90.03
91.00	09100	EMERGENCY	0.304323	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.686003	53,353	36,600	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		3,674,841	1,212,412	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)		3,674,841		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/28/2016 1:02 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,599,372		30.00
31.00	03100	INTENSIVE CARE UNIT		650,115		31.00
40.00	04000	SUBPROVIDER - IPF		944,740		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.263401	740,929	195,161	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692442	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.673579	593,119	399,513	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131961	641,798	84,692	54.00
56.00	05600	RADIOISOTOPE	0.124662	28,893	3,602	56.00
60.00	06000	LABORATORY	0.258082	803,300	207,317	60.00
65.00	06500	RESPIRATORY THERAPY	0.316968	305,941	96,974	65.00
66.00	06600	PHYSICAL THERAPY	0.504822	82,279	41,536	66.00
69.00	06900	ELECTROCARDIOLOGY	0.184994	476,988	88,240	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.319315	0	0	69.02
69.03	06903	SLEEP LAB	0.304428	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.537226	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.742196	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228734	2,412,937	551,921	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.723424	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.558450	9,468	5,287	90.00
90.01	09001	IMED	1.024413	0	0	90.01
90.02	09002	ONCOLOGY	0.455849	7,605	3,467	90.02
90.03	09003	OUTPATIENT CENTER	0.791170	0	0	90.03
91.00	09100	EMERGENCY	0.304323	742,794	226,049	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.686003	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		6,846,051	1,903,759	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)		6,846,051		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150115 | Component CCN: 15S115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/28/2016 1:02 pm

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		473,343		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.263401	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692442	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.673579	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131961	691	91	54.00
56.00	05600	RADIOISOTOPE	0.124662	0	0	56.00
60.00	06000	LABORATORY	0.258082	107,293	27,690	60.00
65.00	06500	RESPIRATORY THERAPY	0.316968	5,153	1,633	65.00
66.00	06600	PHYSICAL THERAPY	0.504822	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.184994	5,546	1,026	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.319315	0	0	69.02
69.03	06903	SLEEP LAB	0.304428	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.537226	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.742196	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228734	78,249	17,898	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.723424	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.558450	0	0	90.00
90.01	09001	IMED	1.024413	0	0	90.01
90.02	09002	ONCOLOGY	0.455849	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.791170	0	0	90.03
91.00	09100	EMERGENCY	0.304323	141,564	43,081	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.686003	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		338,496	91,419	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)		338,496		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150115 | Component CCN: 15T115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/28/2016 1:02 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		98,553		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.263401	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692442	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.673579	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131961	5,228	690	54.00
56.00	05600	RADIOISOTOPE	0.124662	0	0	56.00
60.00	06000	LABORATORY	0.258082	4,578	1,181	60.00
65.00	06500	RESPIRATORY THERAPY	0.316968	8,300	2,631	65.00
66.00	06600	PHYSICAL THERAPY	0.504822	60,932	30,760	66.00
69.00	06900	ELECTROCARDIOLOGY	0.184994	426	79	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.319315	0	0	69.02
69.03	06903	SLEEP LAB	0.304428	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.537226	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.742196	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228734	26,139	5,979	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.723424	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.558450	3,714	2,074	90.00
90.01	09001	IMED	1.024413	0	0	90.01
90.02	09002	ONCOLOGY	0.455849	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.791170	0	0	90.03
91.00	09100	EMERGENCY	0.304323	13	4	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.686003	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		109,330	43,398	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)		109,330		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150115	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/28/2016 1:02 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
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)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	18,284,531	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)	113,026	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)	104.23	4.00
	Indirect Medical Education Adjustment		
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
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
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
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.42	30.00
31.00	Percentage of Medicaid patient days (see instructions)	15.87	31.00
32.00	Sum of lines 30 and 31	18.29	32.00
33.00	Allowable disproportionate share percentage (see instructions)	4.64	33.00
34.00	Disproportionate share adjustment (see instructions)	212,101	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150115	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/28/2016 1:02 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000083671	0.000083685	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	639,948	536,114	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	161,302	401,353	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	562,655		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
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 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 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 an 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)	19,172,313		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	19,172,313	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,457,365	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 intructions)	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)	20,629,678	59.00
60.00	Primary payer payments	5,270	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	20,624,408	61.00
62.00	Deductibles billed to program beneficiaries	2,253,776	62.00
63.00	Coinsurance billed to program beneficiaries	8,911	63.00
64.00	Allowable bad debts (see instructions)	67,362	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	43,785	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	27,574	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	18,405,506	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)	107,709	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150115	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/28/2016 1:02 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)		205,761	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		18,307,454	71.00
71.01	Sequestration adjustment (see instructions)		366,149	71.01
72.00	Interim payments		17,805,487	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)		135,818	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		134,295	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
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	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	18,284,531	0		18,284,531	18,284,531	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	113,026	0	0	113,026	113,026	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0464	0.0464	0.0464	0.0464		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	212,101	0	0	212,101	212,101	11.00
11.01	Uncompensated care payments	36.00	562,655	0	675,373	0	675,373	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	19,172,313	0	675,373	18,496,940	19,172,313	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	19,172,313	0	675,373	18,496,940	19,172,313	15.00
16.00	Payment for inpatient program capital	50.00	1,457,365	0	0	1,457,365	1,457,365	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	675,373	19,954,305	20,629,678	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,449,783	0	0	1,449,783	1,449,783	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	7,582	0	0	7,582	7,582	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,457,365	0	0	1,457,365	1,457,365	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	18,284,531		18,284,531	18,284,531	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	113,026	0	113,026	113,026	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0464	0.0464	0.0464		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	212,101	0	212,101	212,101	11.00
11.01	Uncompensated care payments	36.00	562,655	161,302	401,353	562,655	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	19,172,313	161,302	19,011,011	19,172,313	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	19,172,313	161,302	19,011,011	19,172,313	15.00
16.00	Payment for inpatient program capital	50.00	1,457,365	0	1,457,365	1,457,365	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			161,302	20,468,376	20,629,678	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,449,783	0	1,449,783	1,449,783	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	7,582	0	7,582	7,582	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,457,365	0	1,457,365	1,457,365	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	107,709	0	107,709	107,709	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	205,761	205,761	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150115	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/28/2016 1:02 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	48,720	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	18,322,283	2.00
3.00	PPS payments	19,420,347	3.00
4.00	Outlier payment (see instructions)	20,672	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)	48,720	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	212,922	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)	212,922	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	212,922	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	164,202	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)	48,720	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)	19,441,019	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	126	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,858,138	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)	15,631,475	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)	15,631,475	30.00
31.00	Primary payer payments	7,060	31.00
32.00	Subtotal (line 30 minus line 31)	15,624,415	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	477,660	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	310,479	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	411,556	36.00
37.00	Subtotal (see instructions)	15,934,894	37.00
38.00	MSP-LCC reconciliation amount from PS&R	225	38.00
39.00	OTHER ADJUSTMENT	26,225	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)	15,960,894	40.00
40.01	Sequestration adjustment (see instructions)	319,218	40.01
41.00	Interim payments	15,518,948	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	122,728	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150115 Component CCN: 15S115	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/28/2016 1:02 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	12	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	11	2.00
3.00	PPS payments	28	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	12	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	53	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)	53	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	53	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	41	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)	12	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)	28	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
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)	0	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)	40	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)	40	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	40	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	40	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)	40	40.00
40.01	Sequestration adjustment (see instructions)	1	40.01
41.00	Interim payments	37	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	2	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150115 Component CCN: 15T115	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/28/2016 1:02 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,245	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	286	2.00
3.00	PPS payments	960	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,245	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	5,444	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)	5,444	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	5,444	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	4,199	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)	1,245	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)	960	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
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)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,205	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,205	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,205	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	2,205	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,205	40.00
40.01	Sequestration adjustment (see instructions)	44	40.01
41.00	Interim payments	2,112	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	49	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/28/2016 1:02 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,719	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,719	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	7,516	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	7,516	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	7,516	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	5,797	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)	1,719	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,719	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,719	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,719	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,719	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,719	40.00
40.01	Sequestration adjustment (see instructions)	34	40.01
41.00	Interim payments	1,694	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-9	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2016 1:02 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		17,805,487		15,518,948	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)		17,805,487		15,518,948	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		135,818		122,728	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		17,941,305		15,641,676	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: 150115 | Component CCN: 15S115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Subprovider - IPF | 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		1,385,424		37	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)		1,385,424		37	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		9,062		2	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,394,486		39	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: 150115 | Component CCN: 15T115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Subprovider - IRF | 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		1,466,157		2,112	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)		1,466,157		2,112	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		12,246		49	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,478,403		2,161	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: 150115 Component CCN: 155305	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part I Date/Time Prepared: 11/28/2016 1:02 pm
Title XVIII	Skilled Nursing Facility	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		1,305,321		1,694	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)		1,305,321		1,694	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		2,096		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		9	6.02
7.00	Total Medicare program liability (see instructions)		1,307,417		1,685	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: 150115	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/28/2016 1:02 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	3,817	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	7,462	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	322	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	14,794	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	361,417,578	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	3,216,273	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)	672,544	8.00
9.00	Sequestration adjustment amount (see instructions)	13,451	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	659,093	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	803,522	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)	-144,429	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150115 Component CCN: 15S115	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part II Date/Time Prepared: 11/28/2016 1:02 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,570,440	1.00
2.00	Net IPF PPS Outlier Payments	12,670	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 instuctions)	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 instuctions)	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)	8.040984	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) 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)	1,583,110	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)	1,583,110	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,583,110	18.00
19.00	Deductibles	140,028	19.00
20.00	Subtotal (line 18 minus line 19)	1,443,082	20.00
21.00	Coinsurance	29,351	21.00
22.00	Subtotal (line 20 minus line 21)	1,413,731	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	14,175	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	9,214	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	10,462	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,422,945	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)	1,422,945	31.00
31.01	Sequestration adjustment (see instructions)	28,459	31.01
32.00	Interim payments	1,385,424	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)	9,062	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	12,670	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150115 Component CCN: 15T115	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part III Date/Time Prepared: 11/28/2016 1:02 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	1,464,440	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	23,138	3.00
4.00	Outlier Payments	28,612	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	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	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	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	7.00
8.00	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	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	4.117486	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	1,516,190	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	1,516,190	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	1,516,190	19.00
20.00	Deductibles	7,616	20.00
21.00	Subtotal (line 19 minus line 20)	1,508,574	21.00
22.00	Coinsurance	0	22.00
23.00	Subtotal (line 21 minus line 22)	1,508,574	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	1,508,574	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	1,508,574	32.00
32.01	Sequestration adjustment (see instructions)	30,171	32.01
33.00	Interim payments	1,466,157	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	12,246	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	28,612	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part VI Date/Time Prepared: 11/28/2016 1:02 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,500,586	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,500,586	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	168,627	7.00
8.00	Allowable bad debts (see instructions)	3,292	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	682	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	2,140	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,334,099	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	1,334,099	15.00
15.01	Sequestration adjustment (see instructions)	26,682	15.01
16.00	Interim payments	1,305,321	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	2,096	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G | Date/Time Prepared: 11/28/2016 1:02 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	45,833,334	0	0	0	1.00
2.00	Temporary investments	938,748	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	25,077,696	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	9,171,904	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)	81,021,682	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	9,165,761	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	113,373,872	0	0	0	15.00
16.00	Accumulated depreciation	-61,120,571	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	106,934,937	0	0	0	19.00
20.00	Accumulated depreciation	-70,473,156	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	97,880,843	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	56,534,750	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	8,050,467	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	64,585,217	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	243,487,742	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,981,012	0	0	0	37.00
38.00	Salaries, wages, and fees payable	12,028,505	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,782,965	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	3,828,518				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	20,621,000	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	52,997,234	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	52,997,234	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	73,618,234	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	169,869,508				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)	169,869,508	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	243,487,742	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-1 | Date/Time Prepared: 11/28/2016 1:02 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		169,830,977		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,274,509				2.00
3.00	Total (sum of line 1 and line 2)		176,105,486		0		3.00
4.00	FOUNDATION EXPENSE	1,163,499		0		0	4.00
5.00	NET ASSETS RELEASED	203,264		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)		1,366,763		0		10.00
11.00	Subtotal (line 3 plus line 10)		177,472,249		0		11.00
12.00	AFS	7,602,741		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)		7,602,741		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		169,869,508		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	FOUNDATION EXPENSE		0			4.00
5.00	NET ASSETS RELEASED		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	AFS		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: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/28/2016 1:02 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	18,893,159		18,893,159	1.00
2.00	SUBPROVIDER - IPF	3,991,847		3,991,847	2.00
3.00	SUBPROVIDER - IRF	1,645,405		1,645,405	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,435,705		1,435,705	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	25,966,116		25,966,116	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	8,248,271		8,248,271	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	8,248,271		8,248,271	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	34,214,387		34,214,387	17.00
18.00	Ancillary services	85,719,885	286,495,623	372,215,508	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	845,072	845,072	20.00
20.01	RURAL HEALTH CLINIC II	0	0	0	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,324,811	2,324,811	22.00
23.00	AMBULANCE SERVICES	1,073,827	2,952,176	4,026,003	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	PHYSICIANS	0	52,390,690	52,390,690	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	121,008,099	345,008,372	466,016,471	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		206,961,642		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)		206,961,642		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150115	Period: From 07/01/2015 To 06/30/2016	Worksheet G-3 Date/Time Prepared: 11/28/2016 1:02 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	466,016,471	1.00
2.00	Less contractual allowances and discounts on patients' accounts	253,362,742	2.00
3.00	Net patient revenues (line 1 minus line 2)	212,653,729	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	206,961,642	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,692,087	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	18,113	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	681,101	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	223,768	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	463	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	-341,023	24.00
25.00	Total other income (sum of lines 6-24)	582,422	25.00
26.00	Total (line 5 plus line 25)	6,274,509	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)	6,274,509	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150115 | HHA CCN: 157222 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H | Date/Time Prepared: 11/28/2016 1:02 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	346,951	0	0	46,720	93,508	487,179	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	702,443	0	69,989	0	0	772,432	6.00
7.00	Physical Therapy	209,803	0	35,462	0	0	245,265	7.00
8.00	Occupational Therapy	107,892	0	13,875	0	0	121,767	8.00
9.00	Speech Pathology	6,633	0	670	0	0	7,303	9.00
10.00	Medical Social Services	3,115	0	94	0	0	3,209	10.00
11.00	Home Health Aide	98,546	0	34,255	0	0	132,801	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,475,383	0	154,345	46,720	93,508	1,769,956	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-26,831	460,348	0	460,348			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	772,432	0	772,432			6.00
7.00	Physical Therapy	0	245,265	0	245,265			7.00
8.00	Occupational Therapy	0	121,767	0	121,767			8.00
9.00	Speech Pathology	0	7,303	0	7,303			9.00
10.00	Medical Social Services	0	3,209	0	3,209			10.00
11.00	Home Health Aide	0	132,801	0	132,801			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	-26,831	1,743,125	0	1,743,125			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: 150115 HHA CCN: 157222 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H-1 Part I Date/Time Prepared: 11/28/2016 1:02 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	460,348	0	0	0	0	460,348	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	772,432	0	0	0	0	772,432	6.00
7.00	Physical Therapy	245,265	0	0	0	0	245,265	7.00
8.00	Occupational Therapy	121,767	0	0	0	0	121,767	8.00
9.00	Speech Pathology	7,303	0	0	0	0	7,303	9.00
10.00	Medical Social Services	3,209	0	0	0	0	3,209	10.00
11.00	Home Health Aide	132,801	0	0	0	0	132,801	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,743,125	0	0	0	0	1,743,125	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	460,348		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	277,201	1,049,633	6.00
7.00	Physical Therapy	88,018	333,283	7.00
8.00	Occupational Therapy	43,698	165,465	8.00
9.00	Speech Pathology	2,621	9,924	9.00
10.00	Medical Social Services	1,152	4,361	10.00
11.00	Home Health Aide	47,658	180,459	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		1,743,125	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 150115 HHA CCN: 157222 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H-1 Part II Date/Time Prepared: 11/28/2016 1:02 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-460,348	1,282,777	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	772,432	6.00
7.00	Physical Therapy	0	0	0	0	0	245,265	7.00
8.00	Occupational Therapy	0	0	0	0	0	121,767	8.00
9.00	Speech Pathology	0	0	0	0	0	7,303	9.00
10.00	Medical Social Services	0	0	0	0	0	3,209	10.00
11.00	Home Health Aide	0	0	0	0	0	132,801	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-460,348	1,282,777	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		460,348	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.358868	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150115 | HHA CCN: 157222 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H-2 Part I | Date/Time Prepared: 11/28/2016 1:02 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	16,615	29,843	67,840	114,298	16,781	1.00
2.00	Skilled Nursing Care	1,049,633	0	0	137,349	1,186,982	174,265	2.00
3.00	Physical Therapy	333,283	0	0	41,023	374,306	54,953	3.00
4.00	Occupational Therapy	165,465	0	0	21,096	186,561	27,390	4.00
5.00	Speech Pathology	9,924	0	0	1,297	11,221	1,647	5.00
6.00	Medical Social Services	4,361	0	0	609	4,970	730	6.00
7.00	Home Health Aide	180,459	0	0	19,269	199,728	29,323	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)	1,743,125	16,615	29,843	288,483	2,078,066	305,089	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	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		6.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	48,143	0	9,502	0	5,218	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	10,855	0	2.00
3.00	Physical Therapy	0	0	0	0	3,050	0	3.00
4.00	Occupational Therapy	0	0	0	0	1,348	0	4.00
5.00	Speech Pathology	0	0	0	0	80	0	5.00
6.00	Medical Social Services	0	0	0	0	69	0	6.00
7.00	Home Health Aide	0	0	0	0	2,990	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)	48,143	0	9,502	0	23,610	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: 150115 | HHA CCN: 157222 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H-2 Part I | Date/Time Prepared: 11/28/2016 1:02 pm

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	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	705	0	0	194,647	0	194,647	1.00
2.00	Skilled Nursing Care	0	0	6,756	1,378,858	0	1,378,858	2.00
3.00	Physical Therapy	0	0	3,406	435,715	0	435,715	3.00
4.00	Occupational Therapy	0	0	1,333	216,632	0	216,632	4.00
5.00	Speech Pathology	0	0	64	13,012	0	13,012	5.00
6.00	Medical Social Services	0	0	9	5,778	0	5,778	6.00
7.00	Home Health Aide	0	0	3,290	235,331	0	235,331	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)	705	0	14,858	2,479,973	0	2,479,973	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	117,441	1,496,299					2.00
3.00	Physical Therapy	37,111	472,826					3.00
4.00	Occupational Therapy	18,451	235,083					4.00
5.00	Speech Pathology	1,108	14,120					5.00
6.00	Medical Social Services	492	6,270					6.00
7.00	Home Health Aide	20,044	255,375					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)	194,647	2,479,973					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.	0.085173						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: 150115 HHA CCN: 157222 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H-2 Part II Date/Time Prepared: 11/28/2016 1:02 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	2,579	2,579	346,951	0	114,298	2,579	1.00
2.00	Skilled Nursing Care	0	0	702,443	0	1,186,982	0	2.00
3.00	Physical Therapy	0	0	209,803	0	374,306	0	3.00
4.00	Occupational Therapy	0	0	107,892	0	186,561	0	4.00
5.00	Speech Pathology	0	0	6,633	0	11,221	0	5.00
6.00	Medical Social Services	0	0	3,115	0	4,970	0	6.00
7.00	Home Health Aide	0	0	98,546	0	199,728	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)	2,579	2,579	1,475,383		2,078,066	2,579	20.00
21.00	Total cost to be allocated	16,615	29,843	288,483		305,089	48,143	21.00
22.00	Unit cost multiplier	6.442420	11.571539	0.195531		0.146814	18.667313	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	2,579	0	12,245	0	21,970	1.00
2.00	Skilled Nursing Care	0	0	0	25,470	0	0	2.00
3.00	Physical Therapy	0	0	0	7,157	0	0	3.00
4.00	Occupational Therapy	0	0	0	3,164	0	0	4.00
5.00	Speech Pathology	0	0	0	188	0	0	5.00
6.00	Medical Social Services	0	0	0	162	0	0	6.00
7.00	Home Health Aide	0	0	0	7,017	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	2,579	0	55,403	0	21,970	20.00
21.00	Total cost to be allocated	0	9,502	0	23,610	0	705	21.00
22.00	Unit cost multiplier	0.000000	3.684374	0.000000	0.426150	0.000000	0.032089	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150115 HHA CCN: 157222

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

Worksheet H-2 Part II Date/Time Prepared: 11/28/2016 1:02 pm

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	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)			
		15.00	16.00			
1.00	Administrative and General	0	0			1.00
2.00	Skilled Nursing Care	0	1,057,003			2.00
3.00	Physical Therapy	0	532,970			3.00
4.00	Occupational Therapy	0	208,535			4.00
5.00	Speech Pathology	0	10,072			5.00
6.00	Medical Social Services	0	1,419			6.00
7.00	Home Health Aide	0	514,812			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	2,324,811			20.00
21.00	Total cost to be allocated	0	14,858			21.00
22.00	Unit cost multiplier	0.000000	0.006391			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H-3 Part I
HHA CCN: 157222 | Date/Time Prepared: 11/28/2016 1:02 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,496,299		1,496,299	7,415	201.79	1.00
2.00	Physical Therapy	3.00	472,826	0	472,826	3,757	125.85	2.00
3.00	Occupational Therapy	4.00	235,083	0	235,083	1,470	159.92	3.00
4.00	Speech Pathology	5.00	14,120	0	14,120	71	198.87	4.00
5.00	Medical Social Services	6.00	6,270		6,270	10	627.00	5.00
6.00	Home Health Aide	7.00	255,375		255,375	3,629	70.37	6.00
7.00	Total (sum of lines 1-6)		2,479,973	0	2,479,973	16,352		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		50031	0	0			8.00
8.01	Skilled Nursing Care		50036	0	0			8.01
8.02	Skilled Nursing Care		99915	0	4,020			8.02
9.00	Physical Therapy		50031	0	0			9.00
9.01	Physical Therapy		50036	0	0			9.01
9.02	Physical Therapy		99915	0	2,543			9.02
10.00	Occupational Therapy		50031	0	0			10.00
10.01	Occupational Therapy		50036	0	0			10.01
10.02	Occupational Therapy		99915	0	1,020			10.02
11.00	Speech Pathology		50031	0	0			11.00
11.01	Speech Pathology		50036	0	0			11.01
11.02	Speech Pathology		99915	0	54			11.02
12.00	Medical Social Services		50031	0	0			12.00
12.01	Medical Social Services		50036	0	0			12.01
12.02	Medical Social Services		99915	0	1			12.02
13.00	Home Health Aide		50031	0	0			13.00
13.01	Home Health Aide		50036	0	0			13.01
13.02	Home Health Aide		99915	0	1,940			13.02
14.00	Total (sum of lines 8-13)			0	9,578			14.00

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

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	4,020		0	811,196		1.00
2.00	Physical Therapy	0	2,543		0	320,037		2.00
3.00	Occupational Therapy	0	1,020		0	163,118		3.00
4.00	Speech Pathology	0	54		0	10,739		4.00
5.00	Medical Social Services	0	1		0	627		5.00
6.00	Home Health Aide	0	1,940		0	136,518		6.00
7.00	Total (sum of lines 1-6)	0	9,578		0	1,442,235		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H-3 Part I
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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	65,226	0	0	0	0	15.00
16.00	Cost of Drugs		5,204	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	811,196	1.00
2.00	Physical Therapy	320,037	2.00
3.00	Occupational Therapy	163,118	3.00
4.00	Speech Pathology	10,739	4.00
5.00	Medical Social Services	627	5.00
6.00	Home Health Aide	136,518	6.00
7.00	Total (sum of lines 1-6)	1,442,235	7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150115 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H-3 Part II | Date/Time Prepared: 11/28/2016 1:02 pm

HHA CCN: 157222 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.504822	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.537226	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.228734	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 150115 HHA CCN: 157222 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H-4 Part I-II Date/Time Prepared: 11/28/2016 1:02 pm

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	5,204	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	5,204	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	5,204	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	1,321,759	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	24,103	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	29,678	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	13,577	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	2,760	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	1,391,877	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	1,391,877	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	1,391,877	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	1,391,877	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	1,391,877	31.00
31.01	Sequestration adjustment (see instructions)	0	27,838	31.01
32.00	Interim payments (see instructions)	0	1,364,039	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 150115 HHA CCN: 157222 | Period: From 07/01/2015 To 06/30/2016 | Worksheet H-5 | Date/Time Prepared: 11/28/2016 1:02 pm

Home Health Agency I | 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		1,364,039	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		1,364,039	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		1,364,039	7.00

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

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150115	Period: From 07/01/2015 To 06/30/2016	Worksheet L Parts I-III Date/Time Prepared: 11/28/2016 1:02 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,449,783	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	7,582	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)	41.64	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)	1,457,365	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
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	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
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: 150115 Component CCN: 158507 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-1 | Date/Time Prepared: 11/28/2016 1:02 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	49,822	0	49,822	0	49,822	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	151,441	0	151,441	0	151,441	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	53,722	0	53,722	0	53,722	9.00
10.00	Subtotal (sum of lines 1 through 9)	254,985	0	254,985	0	254,985	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	27,371	27,371	0	27,371	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	26,646	75,558	102,204	0	102,204	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	26,646	102,929	129,575	0	129,575	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	281,631	102,929	384,560	0	384,560	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
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
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	281,631	102,929	384,560	0	384,560	32.00

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

Provider CCN: 150115 | Component CCN: 158507 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-1 | Date/Time Prepared: 11/28/2016 1:02 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	49,822		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	151,441		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	53,722		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	254,985		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	27,371		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	-22,873	79,331		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	-22,873	106,702		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-22,873	361,687		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
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
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-22,873	361,687		32.00

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

Provider CCN: 150115 Component CCN: 158508 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-1 | Date/Time Prepared: 11/28/2016 1:02 pm

Rural Health Clinic (RHC) II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	187,354	0	187,354	0	187,354	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	140,577	0	140,577	0	140,577	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	100,258	0	100,258	0	100,258	9.00
10.00	Subtotal (sum of lines 1 through 9)	428,189	0	428,189	0	428,189	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	24,798	24,798	0	24,798	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	67,293	33,069	100,362	0	100,362	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	67,293	57,867	125,160	0	125,160	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	495,482	57,867	553,349	0	553,349	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
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
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	495,482	57,867	553,349	0	553,349	32.00

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

Provider CCN: 150115 Component CCN: 158508 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-1 | Date/Time Prepared: 11/28/2016 1:02 pm

Rural Health Clinic (RHC) II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	187,354		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	140,577		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	100,258		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	428,189		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	24,798		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	-5,501	94,861		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	-5,501	119,659		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-5,501	547,848		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
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
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-5,501	547,848		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES | Provider CCN: 150115 | Component CCN: 158507 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-2 | Date/Time Prepared: 11/28/2016 1:02 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.12	551	4,200	504		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.03	3,162	2,100	2,163		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.15	3,713		2,667	3,713	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)	1.15	3,713			3,713	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	361,687	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)	361,687	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)	0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	249,658	15.00
16.00	Total overhead (sum of lines 14 and 15)	249,658	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtotal (see instructions)	249,658	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	249,658	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	611,345	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 150115 Component CCN: 158508

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

Worksheet M-2

Date/Time Prepared: 11/28/2016 1:02 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	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.00	3,507	4,200	4,200		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.19	2,687	2,100	2,499		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.19	6,194		6,699	6,699	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)	2.19	6,194			6,699	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					547,848	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)					547,848	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)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					482,669	15.00
16.00	Total overhead (sum of lines 14 and 15)					482,669	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					482,669	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					482,669	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,030,517	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 150115 Component CCN: 158507	Period: From 07/01/2015 To 06/30/2016	Worksheet M-3 Date/Time Prepared: 11/28/2016 1:02 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES		
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)	611,345	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)	5,946	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	605,399	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	3,713	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)	3,713	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	163.05	7.00

		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions)	80.44	81.32	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,488	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	121,004	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) *		121,004	16.00
16.01	Total program charges (see instructions)(from contractor's records)		317,679	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		7,464	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,843	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.)		76,134	16.04
16.05	Total program cost (see instructions)		78,977	16.05
17.00	Primary payer amounts		190	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		22,994	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		57,444	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		78,787	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,035	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		83,822	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)		83,822	26.00
26.01	Sequestration adjustment (see instructions)		1,676	26.01
27.00	Interim payments		74,440	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)		7,706	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: 150115 Component CCN: 158508	Period: From 07/01/2015 To 06/30/2016	Worksheet M-3 Date/Time Prepared: 11/28/2016 1:02 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		1,030,517	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		10,933	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,019,584	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		6,699	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)		6,699	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		152.20	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions)	80.44	81.32	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,855	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	150,849	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) *		150,849	16.00
16.01	Total program charges (see instructions)(from contractor's records)		301,810	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		872	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		436	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.)		92,706	16.04
16.05	Total program cost (see instructions)		93,142	16.05
17.00	Primary payer amounts		157	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		34,530	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		53,282	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		92,985	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		8,504	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		101,489	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)		101,489	26.00
26.01	Sequestration adjustment (see instructions)		2,030	26.01
27.00	Interim payments		87,734	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)		11,725	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: 150115 Component CCN: 158507	Period: From 07/01/2015 To 06/30/2016	Worksheet M-4 Date/Time Prepared: 11/28/2016 1:02 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	254,985	254,985	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)	1,382	2,136	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,382	2,136	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	361,687	361,687	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	249,658	249,658	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003821	0.005906	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	954	1,474	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,336	3,610	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	12	76	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	194.67	47.50	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	10	65	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,947	3,088	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)		5,946	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)		5,035	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 150115 Component CCN: 158508	Period: From 07/01/2015 To 06/30/2016	Worksheet M-4 Date/Time Prepared: 11/28/2016 1:02 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	428,189	428,189	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)	1,036	4,776	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,036	4,776	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	547,848	547,848	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	482,669	482,669	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001891	0.008718	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	913	4,208	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,949	8,984	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	9	171	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	216.56	52.54	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	7	133	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,516	6,988	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)		10,933	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)		8,504	16.00

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

Provider CCN: 150115 Component CCN: 158507 | Period: From 07/01/2015 To 06/30/2016 | Worksheet M-5 | Date/Time Prepared: 11/28/2016 1:02 pm

Rural Health Clinic (RHC) I | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		74,440	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)		74,440	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		7,706	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		82,146	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: 150115 Component CCN: 158508

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

Worksheet M-5

Date/Time Prepared: 11/28/2016 1:02 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		87,734	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)		87,734	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		11,725	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		99,459	7.00

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