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: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 9/6/2016 3:18 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/6/2016 Time: 3:18 pm
2. [ ] Manually submitted cost report
3. [1] 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. [5] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [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 CAMERON MEMORIAL COMMUNITY (151315) for the cost reporting period beginning 10/01/2014 and ending 09/30/2015 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	656,849	20,015	0	-318,202	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	132,144	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	788,993	20,015	0	-318,202	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 9/6/2016 3:17 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 416 E MAUMEE STREET	PO Box:			1.00
2.00	City: ANGOLA	State: IN	Zip Code: 47803-	County: STEUBEN	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	CAMERON MEMORIAL COMMUNITY	151315	99915	1	02/03/2003	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	CAMERON MEMORIAL COMMUNITY	15Z315	99915		02/03/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	CAMERON HOME HEALTH CARE	157117	99915		04/01/1984	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	CAMERON HOSPICE	151561	99915		05/01/1997				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2014	09/30/2015	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 9/6/2016 3:17 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 9/6/2016 3:17 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 9/6/2016 3:17 pm

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	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

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	195,273	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 9/6/2016 3:17 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 9/6/2016 3:17 pm

		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	09/30/2015	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: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 9/6/2016 3:17 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)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	12/30/2015	Y	12/30/2015
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	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 9/6/2016 3:17 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	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	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.	Y	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.	Y	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			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.	KYLE	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957	KCSMITH@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part II Date/Time Prepared: 9/6/2016 3:17 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.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 9/6/2016 3:17 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	23	8,395	78,936.00	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)		23	8,395	78,936.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	2	730	4,320.00	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)		25	9,125	83,256.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	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
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 9/6/2016 3:17 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)	1,171	108	3,289			1.00
2.00	HMO and other (see instructions)	634	467				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	303	0	303			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	380			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,474	108	3,972			7.00
8.00	INTENSIVE CARE UNIT	69	26	180			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		34	434			13.00
14.00	Total (see instructions)	1,543	168	4,586	0.00	321.13	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,030	1,857	7,393	0.00	9.09	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	2.45	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	332.67	27.00
28.00	Observation Bed Days		103	735			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	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 9/6/2016 3:17 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	451	55	1,306	1.00
2.00	HMO and other (see instructions)			226	197		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	451	55	1,306	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	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
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 151315 | Component CCN: 157117 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-4 | Date/Time Prepared: 9/6/2016 3:17 pm

Home Health Agency I | PPS

						1.00	
0.00	County				STUEBEN		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	101.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel			3.03	0.00	3.03	5.00
6.00	Direct Nursing Service			3.72	0.00	3.72	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			2.11	0.00	2.11	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.39	0.00	0.39	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.04	0.00	0.04	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.12	0.00	0.12	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.71	0.00	1.71	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.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99915			20.00
20.01				50031			20.01
		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	727	0	75	6	808	21.00
22.00	Skilled Nursing Visit Charges	135,690	0	13,608	1,166	150,464	22.00
23.00	Physical Therapy Visits	800	0	14	10	824	23.00
24.00	Physical Therapy Visit Charges	164,232	0	2,874	2,053	169,159	24.00
25.00	Occupational Therapy Visits	89	0	1	0	90	25.00
26.00	Occupational Therapy Visit Charges	17,674	0	199	0	17,873	26.00
27.00	Speech Pathology Visits	22	0	3	0	25	27.00
28.00	Speech Pathology Visit Charges	4,369	0	596	0	4,965	28.00
29.00	Medical Social Service Visits	15	0	0	0	15	29.00
30.00	Medical Social Service Visit Charges	3,699	0	0	0	3,699	30.00
31.00	Home Health Aide Visits	265	0	0	3	268	31.00
32.00	Home Health Aide Visit Charges	13,928	0	0	158	14,086	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,918	0	93	19	2,030	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)	339,592	0	17,277	3,377	360,246	35.00
36.00	Total Number of Episodes (standard/non outlier)	112		32	2	146	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	18,359	0	1,599	76	20,034	38.00

HOSPITAL IDENTIFICATION DATA | Provider CCN: 151315 Component CCN: 151561 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-9 Parts I & II Date/Time Prepared: 9/6/2016 3:17 pm

Hospice I

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	3,017	14	404	0	160	3,191	2.00
3.00	Inpatient Respite Care	5	0	0	0	0	5	3.00
4.00	General Inpatient Care	0	0	0	0	0	0	4.00
5.00	Total Hospice Days	3,022	14	404	0	160	3,196	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	80	1	16	0	6	87	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	37.78	14.00	25.25	0.00	26.67	36.74	8.00
9.00	Unduplicated Census Count	75	1	16	0	6	82	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-10 | Date/Time Prepared: 9/6/2016 3:17 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)	0.417855	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,544,200	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	-87,783	5.00
6.00	Medicaid charges	7,652,638	6.00
7.00	Medicaid cost (line 1 times line 6)	3,197,693	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)	1,741,276	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)	1,741,276	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,000,945	48,135	1,049,080	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	418,250	20,113	438,363	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)	418,250	20,113	438,363	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,917,196	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	369,371	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,547,825	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,900,331	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,338,694	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,079,970	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 9/6/2016 3:17 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		3,164,807	3,164,807	-196,860	2,967,947	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,510,716	1,510,716	1,404,538	2,915,254	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,395,180	5,395,180	0	5,395,180	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,676,064	4,309,713	7,985,777	415,982	8,401,759	5.00
7.00	00700	OPERATION OF PLANT	505,778	2,036,056	2,541,834	8,949	2,550,783	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	143,167	143,167	0	143,167	8.00
9.00	00900	HOUSEKEEPING	583,751	276,954	860,705	0	860,705	9.00
10.00	01000	DIETARY	406,889	412,697	819,586	-728,385	91,201	10.00
11.00	01100	CAFETERIA	0	0	0	688,029	688,029	11.00
13.00	01300	NURSING ADMINISTRATION	746,641	31,593	778,234	0	778,234	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	149,869	-34,824	115,045	0	115,045	14.00
15.00	01500	PHARMACY	402,635	1,679,101	2,081,736	0	2,081,736	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	319,570	242,460	562,030	0	562,030	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,508,360	1,247,813	2,756,173	364,814	3,120,987	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	118,069	118,069	31.00
43.00	04300	NURSERY	0	0	0	52,056	52,056	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,598,160	1,624,658	3,222,818	-650,704	2,572,114	50.00
51.00	05100	RECOVERY ROOM	0	0	0	650,704	650,704	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	697,701	93,881	791,582	-534,939	256,643	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,357,421	463,639	1,821,060	0	1,821,060	54.00
60.00	06000	LABORATORY	870,045	1,532,920	2,402,965	0	2,402,965	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	41,665	824,845	866,510	-206,617	659,893	65.00
65.01	06501	SLEEP LAB	0	0	0	195,648	195,648	65.01
66.00	06600	PHYSICAL THERAPY	631,697	41,284	672,981	0	672,981	66.00
69.00	06900	ELECTROCARDIOLOGY	0	275,431	275,431	10,969	286,400	69.00
69.01	06901	CARDIAC REHAB	61,450	49,795	111,245	0	111,245	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,506,085	1,506,085	-382,380	1,123,705	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	382,380	382,380	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	28,122	2,445	30,567	0	30,567	76.00
76.01	03480	ONCOLOGY	0	1,877,122	1,877,122	0	1,877,122	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	128,407	26,904	155,311	0	155,311	90.00
91.00	09100	EMERGENCY	1,477,624	479,483	1,957,107	0	1,957,107	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	668,162	97,359	765,521	-96,321	669,200	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,127,627	1,127,627	-1,127,627	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	132,265	37,839	170,104	-7,225	162,879	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,992,276	30,476,750	46,469,026	361,080	46,830,106	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	9,604	9,604	-8,949	655	194.01
194.02	07952	COMMUNITY HEALTH	81,127	7,469	88,596	0	88,596	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	85,369	54,421	139,790	-115,043	24,747	194.04
194.05	07955	MARKETING	157,018	479,203	636,221	-133,495	502,726	194.05
194.06	07956	GUEST MEALS	0	0	0	40,356	40,356	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	1,071,234	317,602	1,388,836	-143,949	1,244,887	194.09
200.00		TOTAL (SUM OF LINES 118-199)	17,387,024	31,345,049	48,732,073	0	48,732,073	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 9/6/2016 3:17 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	-697,026	2,270,921		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-317,645	2,597,609		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-194,356	5,200,824		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-490,410	7,911,349		5.00
7.00	00700	OPERATION OF PLANT	-3,300	2,547,483		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	143,167		8.00
9.00	00900	HOUSEKEEPING	0	860,705		9.00
10.00	01000	DIETARY	-14,471	76,730		10.00
11.00	01100	CAFETERIA	-290,092	397,937		11.00
13.00	01300	NURSING ADMINISTRATION	0	778,234		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	115,045		14.00
15.00	01500	PHARMACY	-103,498	1,978,238		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-338	561,692		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-703,518	2,417,469		30.00
31.00	03100	INTENSIVE CARE UNIT	0	118,069		31.00
43.00	04300	NURSERY	0	52,056		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,034,165	1,537,949		50.00
51.00	05100	RECOVERY ROOM	0	650,704		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-20,760	235,883		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,821,060		54.00
60.00	06000	LABORATORY	-10,750	2,392,215		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	659,893		65.00
65.01	06501	SLEEP LAB	0	195,648		65.01
66.00	06600	PHYSICAL THERAPY	0	672,981		66.00
69.00	06900	ELECTROCARDIOLOGY	0	286,400		69.00
69.01	06901	CARDIAC REHAB	0	111,245		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,123,705		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	382,380		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	30,567		76.00
76.01	03480	ONCOLOGY	0	1,877,122		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	155,311		90.00
91.00	09100	EMERGENCY	-421	1,956,686		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	669,200		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0		114.00
116.00	11600	HOSPICE	0	162,879		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,880,750	42,949,356		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0		194.00
194.01	07951	MOB	0	655		194.01
194.02	07952	COMMUNITY HEALTH	0	88,596		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0		194.03
194.04	07954	EDUCATION	0	24,747		194.04
194.05	07955	MARKETING	0	502,726		194.05
194.06	07956	GUEST MEALS	0	40,356		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0		194.07
194.08	07958	CANCER CENTER	0	0		194.08
194.09	07959	URGENT CARE	0	1,244,887		194.09
200.00		TOTAL (SUM OF LINES 118-199)	-3,880,750	44,851,323		200.00

RECLASSIFICATIONS | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 9/6/2016 3:17 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LABOR AND DELIVERY				
1.00	ADULTS & PEDIATRICS	30.00	425,613	57,270	1.00
2.00	NURSERY	43.00	45,882	6,174	2.00
	0		471,495	63,444	
	B - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	68,650	1.00
	0		0	68,650	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	341,577	346,452	1.00
2.00	GUEST MEALS	194.06	20,035	20,321	2.00
	0		361,612	366,773	
	D - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,048,885	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	78,742	2.00
	0		0	1,127,627	
	E - DEPRECIATION EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,325,796	1.00
	0		0	1,325,796	
	F - ICU				
1.00	INTENSIVE CARE UNIT	31.00	65,391	52,678	1.00
	0		65,391	52,678	
	G - ADVERTISING COST				
1.00	ADMINISTRATIVE & GENERAL	5.00	25,698	196,416	1.00
	0		25,698	196,416	
	H - PROPERTY TAX				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	11,401	1.00
	0		0	11,401	
	I - EDUCATION COSTS				
1.00	ADMINISTRATIVE & GENERAL	5.00	85,369	29,674	1.00
	0		85,369	29,674	
	J - SLEEP LAB				
1.00	SLEEP LAB	65.01	0	195,648	1.00
2.00	ELECTROCARDIOLOGY	69.00	0	10,969	2.00
	0		0	206,617	
	K - UTILITIES				
1.00	OPERATION OF PLANT	7.00	0	8,949	1.00
	0		0	8,949	
	L - PUBLIC RELATIONS				
1.00	MARKETING	194.05	0	88,619	1.00
	0		0	88,619	
	M - MSW				
1.00	HOME HEALTH AGENCY	101.00	7,225	0	1.00
	0		7,225	0	
	N - RECOVERY ROOM				
1.00	RECOVERY ROOM	51.00	650,704	0	1.00
	0		650,704	0	
	O - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	382,380	1.00
	0		0	382,380	
	P - HOME HEALTH				
1.00	ADMINISTRATIVE & GENERAL	5.00	103,546	0	1.00
	0		103,546	0	
	Q - URGENT CARE				
1.00	ADMINISTRATIVE & GENERAL	5.00	143,949	0	1.00
	0		143,949	0	
500.00	Grand Total: Increases		1,914,989	3,929,024	500.00

RECLASSIFICATIONS | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 9/6/2016 3:17 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - LABOR AND DELIVERY					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	471,495	63,444	0	1.00
2.00		0.00	0	0	0	2.00
	0		471,495	63,444		
	B - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	68,650	12	1.00
	0		0	68,650		
	C - CAFETERIA					
1.00	DIETARY	10.00	361,612	366,773	0	1.00
2.00		0.00	0	0	0	2.00
	0		361,612	366,773		
	D - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	1,127,627	11	1.00
2.00		0.00	0	0	11	2.00
	0		0	1,127,627		
	E - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,325,796	9	1.00
	0		0	1,325,796		
	F - ICU					
1.00	ADULTS & PEDIATRICS	30.00	65,391	52,678	0	1.00
	0		65,391	52,678		
	G - ADVERTISING COST					
1.00	MARKETING	194.05	25,698	196,416	0	1.00
	0		25,698	196,416		
	H - PROPERTY TAX					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,401	13	1.00
	0		0	11,401		
	I - EDUCATION COSTS					
1.00	EDUCATION	194.04	85,369	29,674	0	1.00
	0		85,369	29,674		
	J - SLEEP LAB					
1.00	RESPIRATORY THERAPY	65.00	0	206,617	0	1.00
2.00		0.00	0	0	0	2.00
	0		0	206,617		
	K - UTILITIES					
1.00	MOB	194.01	0	8,949	0	1.00
	0		0	8,949		
	L - PUBLIC RELATIONS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	88,619	0	1.00
	0		0	88,619		
	M - MSW					
1.00	HOSPICE	116.00	7,225	0	0	1.00
	0		7,225	0		
	N - RECOVERY ROOM					
1.00	OPERATING ROOM	50.00	650,704	0	0	1.00
	0		650,704	0		
	O - IMPLANTABLE DEVICES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	382,380	0	1.00
	0		0	382,380		
	P - HOME HEALTH					
1.00	HOME HEALTH AGENCY	101.00	103,546	0	0	1.00
	0		103,546	0		
	Q - URGENT CARE					
1.00	URGENT CARE	194.09	143,949	0	0	1.00
	0		143,949	0		
500.00	Grand Total: Decreases		1,914,989	3,929,024		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 9/6/2016 3:17 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	750,190	567,678	0	567,678	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	55,488,169	9,448,483	0	9,448,483	12,504,950	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	18,170,884	6,078,234	0	6,078,234	8,949,322	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	74,409,243	16,094,395	0	16,094,395	21,454,272	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	74,409,243	16,094,395	0	16,094,395	21,454,272	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,317,868	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	52,431,702	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	15,299,796	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	69,049,366	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	69,049,366	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 9/6/2016 3:17 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	3,164,807	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,164,807	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3,164,807	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,510,716	1,510,716	2.00
3.00	Total (sum of lines 1-2)	1,510,716	4,675,523	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 9/6/2016 3:17 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	53,749,570	0	53,749,570	0.778422	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,299,796	0	15,299,796	0.221578	0	2.00
3.00	Total (sum of lines 1-2)	69,049,366	0	69,049,366	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,809,152	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,151,344	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,960,496	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	381,718	68,650	11,401	0	2,270,921	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-64,451	0	0	1,510,716	2,597,609	2.00
3.00	Total (sum of lines 1-2)	317,267	68,650	11,401	1,510,716	4,868,530	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 9/6/2016 3:17 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)	A	-667,167	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	-50,086	CAP REL COSTS-MVBLE EQUIP	2.00	11	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)	B	-18,468	CAP REL COSTS-MVBLE EQUIP	2.00	9	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,769,193			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-356,313			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-262,687	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	-103,498	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-338	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	-21,285	CAFETERIA	11.00	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	UTILIZATION REVIEW-SNF	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	A	-33,481	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	LOBBYING EXPENSES	A	-3,901	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	EMPLOYEE CHRISTMAS PARTY	A	-15,918	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 9/6/2016 3:17 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	
33.02	PHYSICIAN RECRUITMENT	A	-44,185	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MEALS ON WHEELS	B	-14,211	DIETARY	10.00	0	33.03
33.04	BREAKFAST CART	B	-260	DIETARY	10.00	0	33.04
33.05	REIMBURSEMENT FOUNDATION DEVELOPMENT	B	-72,587	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	RENTAL INCOME OFFSET - CANCER CENTER	B	-29,859	CAP REL COSTS-BLDG & FIXT	1.00	9	33.06
33.07	ATM SURCHARGE REVENUE	B	-772	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	OP EDUCATION	B	-989	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	EMS	B	-421	EMERGENCY	91.00	0	33.09
33.10	DIETICIAN CONSULTATIONS	B	-6,120	CAFETERIA	11.00	0	33.10
33.11	HAF EXPENSE	A	-315,904	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	RENT EXPENSE OFFSET	A	-93,107	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,880,750				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: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8-1 Date/Time Prepared: 9/6/2016 3:17 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO OVERHEAD - BENEFITS	0	193,367	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	CMO OVERHEAD - A&G	0	37,143	2.00
3.00	7.00	OPERATION OF PLANT	CMO OVERHEAD - PLANT OPS	0	3,300	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	RENT PAID TO CMO	393,839	516,342	4.00
5.00	0		0	393,839	750,152	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	CAMERON MEDICAL	100.00		0.00	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: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8-1 Date/Time Prepared: 9/6/2016 3:17 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	-193,367	0		1.00
2.00	-37,143	0		2.00
3.00	-3,300	0		3.00
4.00	-122,503	9		4.00
5.00	-356,313			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			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: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 9/6/2016 3:17 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	60.00	LABORATORY	18,000	10,750	7,250	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	707,318	670,818	36,500	0	0	2.00
3.00	50.00	OPERATING ROOM	1,054,165	1,034,165	20,000	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	32,700	32,700	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	20,760	20,760	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,832,943	1,769,193	63,750		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	10,750		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	670,818		2.00
3.00	50.00	OPERATING ROOM	0	0	0	1,034,165		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	32,700		4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	20,760		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,769,193		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 9/6/2016 3:17 pm

		Respiratory Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		3.25	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	2,082.50	20,384.74	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	62.88	62.88	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	31.44	31.44	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	130,948	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	1,281,792	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	1,412,740	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	1,412,740	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	1,412,740	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	11,476	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	11,476	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,186	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	12,662	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	12,662	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 9/6/2016 3:17 pm

		Respiratory Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	521.25	0.00	0.00	0.00	521.25	47.00
48.00	Overtime rate (see instructions)	94.32	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	49,164.30	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	100.00	0.00	0.00	0.00	100.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	2,080.00	0.00	0.00	0.00	2,080.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	62.88	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	130,790	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	49,164	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	32,776	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	16,388	0	0	0	16,388	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		1,412,740	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		12,662	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		16,388	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		1,441,790	63.00
64.00	Total cost of outside supplier services (from your records)		537,637	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		11,476	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,186	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		12,662	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,186	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		1,186	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 9/6/2016 3:17 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	2,270,921	2,270,921				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,597,609		2,597,609			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,200,824	12,879	12,580	5,226,283		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,911,349	107,285	177,906	1,212,752	9,409,292	5.00
7.00	00700	OPERATION OF PLANT	2,547,483	225,920	264,748	152,029	3,190,180	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	143,167	23,181	22,643	0	188,991	8.00
9.00	00900	HOUSEKEEPING	860,705	7,334	7,164	175,467	1,050,670	9.00
10.00	01000	DIETARY	76,730	85,609	83,623	13,610	259,572	10.00
11.00	01100	CAFETERIA	397,937	43,329	42,323	102,673	586,262	11.00
13.00	01300	NURSING ADMINISTRATION	778,234	18,292	17,867	224,429	1,038,822	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	115,045	68,016	66,438	45,048	294,547	14.00
15.00	01500	PHARMACY	1,978,238	25,211	24,626	121,026	2,149,101	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	561,692	0	23,603	96,058	681,353	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,417,469	336,152	328,348	561,668	3,643,637	30.00
31.00	03100	INTENSIVE CARE UNIT	118,069	25,757	25,159	19,656	188,641	31.00
43.00	04300	NURSERY	52,056	9,168	8,955	13,791	83,970	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,537,949	237,271	231,764	284,791	2,291,775	50.00
51.00	05100	RECOVERY ROOM	650,704	155,132	151,531	195,592	1,152,959	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	235,883	71,399	69,742	67,994	445,018	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,821,060	166,635	162,768	408,020	2,558,483	54.00
60.00	06000	LABORATORY	2,392,215	60,551	59,146	261,522	2,773,434	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	659,893	16,808	16,417	12,524	705,642	65.00
65.01	06501	SLEEP LAB	195,648	0	55,436	0	251,084	65.01
66.00	06600	PHYSICAL THERAPY	672,981	121,931	119,101	189,879	1,103,892	66.00
69.00	06900	ELECTROCARDIOLOGY	286,400	3,121	3,049	0	292,570	69.00
69.01	06901	CARDIAC REHAB	111,245	26,543	25,927	18,471	182,186	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,123,705	0	0	0	1,123,705	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	382,380	0	0	0	382,380	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	30,567	0	8,806	8,453	47,826	76.00
76.01	03480	ONCOLOGY	1,877,122	242,291	236,668	0	2,356,081	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	155,311	14,668	14,328	38,597	222,904	90.00
91.00	09100	EMERGENCY	1,956,686	150,264	146,777	444,152	2,697,879	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	669,200	0	31,321	171,887	872,408	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	162,879	0	6,418	37,585	206,882	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,949,356	2,254,747	2,445,182	4,877,674	42,432,146	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,660	12,366	0	25,026	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	655	0	0	0	655	194.01
194.02	07952	COMMUNITY HEALTH	88,596	0	0	24,386	112,982	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	24,747	0	0	0	24,747	194.04
194.05	07955	MARKETING	502,726	3,514	3,433	39,473	549,146	194.05
194.06	07956	GUEST MEALS	40,356	0	0	6,022	46,378	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	1,244,887	0	136,628	278,728	1,660,243	194.09
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	44,851,323	2,270,921	2,597,609	5,226,283	44,851,323	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 9/6/2016 3:17 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	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	9,409,292					5.00
7.00	00700	OPERATION OF PLANT	846,942	4,037,122				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	50,174	42,669	281,834			8.00
9.00	00900	HOUSEKEEPING	278,936	13,500	69,588	1,412,694		9.00
10.00	01000	DIETARY	68,912	157,580	1,759	9,819	497,642	10.00
11.00	01100	CAFETERIA	155,643	79,754	2,353	72,664	0	11.00
13.00	01300	NURSING ADMINISTRATION	275,791	33,669	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,198	125,196	200	23,567	0	14.00
15.00	01500	PHARMACY	570,552	46,406	0	13,747	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	180,888	44,477	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	967,326	618,746	58,380	430,422	471,817	30.00
31.00	03100	INTENSIVE CARE UNIT	50,081	47,410	1,402	18,002	25,825	31.00
43.00	04300	NURSERY	22,293	16,875	12,110	85,429	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	608,430	436,739	40,887	158,421	0	50.00
51.00	05100	RECOVERY ROOM	306,092	285,548	2,816	10,474	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	118,145	131,423	3,555	24,221	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	679,236	306,722	23,307	115,542	0	54.00
60.00	06000	LABORATORY	736,302	111,455	507	72,991	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	187,337	30,937	100	19,966	0	65.00
65.01	06501	SLEEP LAB	66,659	104,464	4,106	15,384	0	65.01
66.00	06600	PHYSICAL THERAPY	293,066	224,436	6,565	75,610	0	66.00
69.00	06900	ELECTROCARDIOLOGY	77,673	5,746	0	0	0	69.00
69.01	06901	CARDIAC REHAB	48,367	48,857	701	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	298,326	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	101,516	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	12,697	16,594	0	4,582	0	76.00
76.01	03480	ONCOLOGY	625,502	445,980	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	59,177	27,000	0	0	0	90.00
91.00	09100	EMERGENCY	716,244	276,588	52,741	179,369	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	231,610	59,022	219	6,219	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	54,924	12,094	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,767,039	3,749,887	281,296	1,336,429	497,642	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,644	23,303	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	174	0	538	0	0	194.01
194.02	07952	COMMUNITY HEALTH	29,995	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	6,570	0	0	0	0	194.04
194.05	07955	MARKETING	145,789	6,469	0	0	0	194.05
194.06	07956	GUEST MEALS	12,313	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	440,768	257,463	0	76,265	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)	9,409,292	4,037,122	281,834	1,412,694	497,642	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 9/6/2016 3:17 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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	896,676					11.00
13.00	01300	NURSING ADMINISTRATION	44,999	1,393,281				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,551	0	541,259			14.00
15.00	01500	PHARMACY	22,999	0	2,189	2,804,994		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	37,061	0	70	0	943,849	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	171,381	533,389	21,947	0	11,596	30.00
31.00	03100	INTENSIVE CARE UNIT	6,487	20,175	0	0	1,427	31.00
43.00	04300	NURSERY	3,039	9,497	0	0	2,161	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	68,452	213,123	65,284	0	26,466	50.00
51.00	05100	RECOVERY ROOM	46,451	144,594	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,060	46,833	8,192	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,616	0	6,739	0	209,083	54.00
60.00	06000	LABORATORY	89,364	0	141,465	0	289,529	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,814	0	4,571	0	26,888	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	49,490	0	1,440	0	89,622	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	500	0	50,523	69.00
69.01	06901	CARDIAC REHAB	4,672	0	255	0	32,324	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	204,188	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	51,964	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,804,994	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	3,810	0	3	0	2,302	76.00
76.01	03480	ONCOLOGY	0	0	106	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	11,703	36,468	2,843	0	40,126	90.00
91.00	09100	EMERGENCY	125,018	389,202	22,715	0	161,802	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	41,234	0	1,692	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	11,114	0	395	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	873,315	1,393,281	536,558	2,804,994	943,849	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	111	0	0	194.01
194.02	07952	COMMUNITY HEALTH	6,260	0	513	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	13,790	0	238	0	0	194.05
194.06	07956	GUEST MEALS	3,311	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	3,839	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)	896,676	1,393,281	541,259	2,804,994	943,849	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 9/6/2016 3:17 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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	6,928,641	0	6,928,641		30.00
31.00	03100	INTENSIVE CARE UNIT	359,450	0	359,450		31.00
43.00	04300	NURSERY	235,374	0	235,374		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,909,577	0	3,909,577		50.00
51.00	05100	RECOVERY ROOM	1,948,934	0	1,948,934		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	792,447	0	792,447		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,998,728	0	3,998,728		54.00
60.00	06000	LABORATORY	4,215,047	0	4,215,047		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	977,255	0	977,255		65.00
65.01	06501	SLEEP LAB	441,697	0	441,697		65.01
66.00	06600	PHYSICAL THERAPY	1,844,121	0	1,844,121		66.00
69.00	06900	ELECTROCARDIOLOGY	427,012	0	427,012		69.00
69.01	06901	CARDIAC REHAB	317,362	0	317,362		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,626,219	0	1,626,219		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	535,860	0	535,860		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,804,994	0	2,804,994		73.00
76.00	03020	CHEMICAL DEPENDENCY	87,814	0	87,814		76.00
76.01	03480	ONCOLOGY	3,427,669	0	3,427,669		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	400,221	0	400,221		90.00
91.00	09100	EMERGENCY	4,621,558	0	4,621,558		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	1,212,404	0	1,212,404		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	285,409	0	285,409		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,397,793	0	41,397,793		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	54,973	0	54,973		190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0		194.00
194.01	07951	MOB	1,478	0	1,478		194.01
194.02	07952	COMMUNITY HEALTH	149,750	0	149,750		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0		194.03
194.04	07954	EDUCATION	31,317	0	31,317		194.04
194.05	07955	MARKETING	715,432	0	715,432		194.05
194.06	07956	GUEST MEALS	62,002	0	62,002		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0		194.08
194.09	07959	URGENT CARE	2,438,578	0	2,438,578		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)	44,851,323	0	44,851,323		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/6/2016 3:17 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	12,879	12,580	25,459	25,459	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	107,285	177,906	285,191	5,912	5.00
7.00	00700	OPERATION OF PLANT	0	225,920	264,748	490,668	740	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	23,181	22,643	45,824	0	8.00
9.00	00900	HOUSEKEEPING	0	7,334	7,164	14,498	855	9.00
10.00	01000	DIETARY	0	85,609	83,623	169,232	66	10.00
11.00	01100	CAFETERIA	0	43,329	42,323	85,652	500	11.00
13.00	01300	NURSING ADMINISTRATION	0	18,292	17,867	36,159	1,093	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	68,016	66,438	134,454	219	14.00
15.00	01500	PHARMACY	0	25,211	24,626	49,837	589	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	23,603	23,603	468	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	336,152	328,348	664,500	2,736	30.00
31.00	03100	INTENSIVE CARE UNIT	0	25,757	25,159	50,916	96	31.00
43.00	04300	NURSERY	0	9,168	8,955	18,123	67	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	237,271	231,764	469,035	1,387	50.00
51.00	05100	RECOVERY ROOM	0	155,132	151,531	306,663	953	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	71,399	69,742	141,141	331	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	166,635	162,768	329,403	1,987	54.00
60.00	06000	LABORATORY	0	60,551	59,146	119,697	1,274	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	16,808	16,417	33,225	61	65.00
65.01	06501	SLEEP LAB	0	0	55,436	55,436	0	65.01
66.00	06600	PHYSICAL THERAPY	0	121,931	119,101	241,032	925	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,121	3,049	6,170	0	69.00
69.01	06901	CARDIAC REHAB	0	26,543	25,927	52,470	90	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	8,806	8,806	41	76.00
76.01	03480	ONCOLOGY	0	242,291	236,668	478,959	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	14,668	14,328	28,996	188	90.00
91.00	09100	EMERGENCY	0	150,264	146,777	297,041	2,163	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	31,321	31,321	837	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	6,418	6,418	183	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,254,747	2,445,182	4,699,929	23,761	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,660	12,366	25,026	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	119	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	0	3,514	3,433	6,947	192	194.05
194.06	07956	GUEST MEALS	0	0	0	0	29	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	136,628	136,628	1,358	194.09
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	2,270,921	2,597,609	4,868,530	25,459	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/6/2016 3:17 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	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	291,103					5.00
7.00	00700	OPERATION OF PLANT	26,201	517,609				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,552	5,471	52,847			8.00
9.00	00900	HOUSEKEEPING	8,629	1,731	13,048	38,761		9.00
10.00	01000	DIETARY	2,132	20,204	330	269	192,233	10.00
11.00	01100	CAFETERIA	4,815	10,225	441	1,994	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,532	4,317	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,419	16,052	38	647	0	14.00
15.00	01500	PHARMACY	17,651	5,950	0	377	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,596	5,703	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,944	79,326	10,947	11,808	182,257	30.00
31.00	03100	INTENSIVE CARE UNIT	1,549	6,079	263	494	9,976	31.00
43.00	04300	NURSERY	690	2,164	2,271	2,344	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,822	55,995	7,667	4,347	0	50.00
51.00	05100	RECOVERY ROOM	9,469	36,611	528	287	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,655	16,850	667	665	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,013	39,326	4,370	3,170	0	54.00
60.00	06000	LABORATORY	22,778	14,290	95	2,003	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,795	3,967	19	548	0	65.00
65.01	06501	SLEEP LAB	2,062	13,394	770	422	0	65.01
66.00	06600	PHYSICAL THERAPY	9,066	28,776	1,231	2,075	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,403	737	0	0	0	69.00
69.01	06901	CARDIAC REHAB	1,496	6,264	131	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,229	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,140	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	393	2,128	0	126	0	76.00
76.01	03480	ONCOLOGY	19,350	57,180	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,831	3,462	0	0	0	90.00
91.00	09100	EMERGENCY	22,158	35,462	9,889	4,921	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	7,165	7,567	41	171	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,699	1,551	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	271,234	480,782	52,746	36,668	192,233	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	206	2,988	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	5	0	101	0	0	194.01
194.02	07952	COMMUNITY HEALTH	928	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	203	0	0	0	0	194.04
194.05	07955	MARKETING	4,510	829	0	0	0	194.05
194.06	07956	GUEST MEALS	381	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	13,636	33,010	0	2,093	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)	291,103	517,609	52,847	38,761	192,233	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/6/2016 3:17 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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	103,627					11.00
13.00	01300	NURSING ADMINISTRATION	5,200	55,301				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,259	0	156,088			14.00
15.00	01500	PHARMACY	2,658	0	631	77,693		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,283	0	20	0	39,673	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,808	21,171	6,329	0	487	30.00
31.00	03100	INTENSIVE CARE UNIT	750	801	0	0	60	31.00
43.00	04300	NURSERY	351	377	0	0	91	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,911	8,459	18,827	0	1,112	50.00
51.00	05100	RECOVERY ROOM	5,368	5,739	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,740	1,859	2,363	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,512	0	1,943	0	8,788	54.00
60.00	06000	LABORATORY	10,328	0	40,796	0	12,170	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	210	0	1,318	0	1,130	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	5,719	0	415	0	3,767	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	144	0	2,124	69.00
69.01	06901	CARDIAC REHAB	540	0	74	0	1,359	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	58,882	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	14,985	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	77,693	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	440	0	1	0	97	76.00
76.01	03480	ONCOLOGY	0	0	31	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,353	1,447	820	0	1,687	90.00
91.00	09100	EMERGENCY	14,448	15,448	6,551	0	6,801	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	4,765	0	488	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,284	0	114	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100,927	55,301	154,732	77,693	39,673	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	32	0	0	194.01
194.02	07952	COMMUNITY HEALTH	723	0	148	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	1,594	0	69	0	0	194.05
194.06	07956	GUEST MEALS	383	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	1,107	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)	103,627	55,301	156,088	77,693	39,673	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/6/2016 3:17 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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,029,313	0	1,029,313		30.00
31.00	03100	INTENSIVE CARE UNIT	70,984	0	70,984		31.00
43.00	04300	NURSERY	26,478	0	26,478		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	593,562	0	593,562		50.00
51.00	05100	RECOVERY ROOM	365,618	0	365,618		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	169,271	0	169,271		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	421,512	0	421,512		54.00
60.00	06000	LABORATORY	223,431	0	223,431		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	46,273	0	46,273		65.00
65.01	06501	SLEEP LAB	72,084	0	72,084		65.01
66.00	06600	PHYSICAL THERAPY	293,006	0	293,006		66.00
69.00	06900	ELECTROCARDIOLOGY	11,578	0	11,578		69.00
69.01	06901	CARDIAC REHAB	62,424	0	62,424		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68,111	0	68,111		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,125	0	18,125		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,693	0	77,693		73.00
76.00	03020	CHEMICAL DEPENDENCY	12,032	0	12,032		76.00
76.01	03480	ONCOLOGY	555,520	0	555,520		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	39,784	0	39,784		90.00
91.00	09100	EMERGENCY	414,882	0	414,882		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	52,355	0	52,355		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	11,249	0	11,249		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,635,285	0	4,635,285		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,220	0	28,220		190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0		194.00
194.01	07951	MOB	138	0	138		194.01
194.02	07952	COMMUNITY HEALTH	1,918	0	1,918		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0		194.03
194.04	07954	EDUCATION	203	0	203		194.04
194.05	07955	MARKETING	14,141	0	14,141		194.05
194.06	07956	GUEST MEALS	793	0	793		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0		194.08
194.09	07959	URGENT CARE	187,832	0	187,832		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)	4,868,530	0	4,868,530		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/6/2016 3:17 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	104,037					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		121,831				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	590	590	17,387,024			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,915	8,344	4,034,626	-9,409,292	35,442,031	5.00
7.00	00700	OPERATION OF PLANT	10,350	12,417	505,778	0	3,190,180	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	1,062	0	0	188,991	8.00
9.00	00900	HOUSEKEEPING	336	336	583,751	0	1,050,670	9.00
10.00	01000	DIETARY	3,922	3,922	45,277	0	259,572	10.00
11.00	01100	CAFETERIA	1,985	1,985	341,577	0	586,262	11.00
13.00	01300	NURSING ADMINISTRATION	838	838	746,641	0	1,038,822	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,116	3,116	149,869	0	294,547	14.00
15.00	01500	PHARMACY	1,155	1,155	402,635	0	2,149,101	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,107	319,570	0	681,353	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,400	15,400	1,868,582	0	3,643,637	30.00
31.00	03100	INTENSIVE CARE UNIT	1,180	1,180	65,391	0	188,641	31.00
43.00	04300	NURSERY	420	420	45,882	0	83,970	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,870	10,870	947,456	0	2,291,775	50.00
51.00	05100	RECOVERY ROOM	7,107	7,107	650,704	0	1,152,959	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,271	3,271	226,206	0	445,018	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,634	7,634	1,357,421	0	2,558,483	54.00
60.00	06000	LABORATORY	2,774	2,774	870,045	0	2,773,434	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	770	770	41,665	0	705,642	65.00
65.01	06501	SLEEP LAB	0	2,600	0	0	251,084	65.01
66.00	06600	PHYSICAL THERAPY	5,586	5,586	631,697	0	1,103,892	66.00
69.00	06900	ELECTROCARDIOLOGY	143	143	0	0	292,570	69.00
69.01	06901	CARDIAC REHAB	1,216	1,216	61,450	0	182,186	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,123,705	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	382,380	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	413	28,122	0	47,826	76.00
76.01	03480	ONCOLOGY	11,100	11,100	0	0	2,356,081	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	672	672	128,407	0	222,904	90.00
91.00	09100	EMERGENCY	6,884	6,884	1,477,624	0	2,697,879	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,469	571,841	0	872,408	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	301	125,040	0	206,882	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	103,296	114,682	16,227,257	-9,409,292	33,022,854	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	580	580	0	0	25,026	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	655	194.01
194.02	07952	COMMUNITY HEALTH	0	0	81,127	0	112,982	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	24,747	194.04
194.05	07955	MARKETING	161	161	131,320	0	549,146	194.05
194.06	07956	GUEST MEALS	0	0	20,035	0	46,378	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	6,408	927,285	0	1,660,243	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)	2,270,921	2,597,609	5,226,283		9,409,292	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.828013	21.321412	0.300585		0.265484	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			25,459		291,103	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001464		0.008213	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/6/2016 3:17 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	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
7.00	00700	OPERATION OF PLANT	100,480					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	45,032				8.00
9.00	00900	HOUSEKEEPING	336	11,119	4,316			9.00
10.00	01000	DIETARY	3,922	281	30	13,990		10.00
11.00	01100	CAFETERIA	1,985	376	222	0	19,767	11.00
13.00	01300	NURSING ADMINISTRATION	838	0	0	0	992	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,116	32	72	0	431	14.00
15.00	01500	PHARMACY	1,155	0	42	0	507	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,107	0	0	0	817	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,400	9,328	1,315	13,264	3,778	30.00
31.00	03100	INTENSIVE CARE UNIT	1,180	224	55	726	143	31.00
43.00	04300	NURSERY	420	1,935	261	0	67	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,870	6,533	484	0	1,509	50.00
51.00	05100	RECOVERY ROOM	7,107	450	32	0	1,024	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,271	568	74	0	332	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,634	3,724	353	0	2,196	54.00
60.00	06000	LABORATORY	2,774	81	223	0	1,970	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	770	16	61	0	40	65.00
65.01	06501	SLEEP LAB	2,600	656	47	0	0	65.01
66.00	06600	PHYSICAL THERAPY	5,586	1,049	231	0	1,091	66.00
69.00	06900	ELECTROCARDIOLOGY	143	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	1,216	112	0	0	103	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	413	0	14	0	84	76.00
76.01	03480	ONCOLOGY	11,100	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	672	0	0	0	258	90.00
91.00	09100	EMERGENCY	6,884	8,427	548	0	2,756	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,469	35	19	0	909	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	301	0	0	0	245	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	93,331	44,946	4,083	13,990	19,252	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	580	0	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	86	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	138	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	161	0	0	0	304	194.05
194.06	07956	GUEST MEALS	0	0	0	0	73	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	6,408	0	233	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)	4,037,122	281,834	1,412,694	497,642	896,676	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	40.178364	6.258527	327.315570	35.571265	45.362270	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	517,609	52,847	38,761	192,233	103,627	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.151363	1.173543	8.980769	13.740743	5.242424	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/6/2016 3:17 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	205,243					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,179,634				14.00
15.00	01500	PHARMACY	0	12,857	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	414	0	87,337		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	78,573	128,925	0	1,073		30.00
31.00	03100	INTENSIVE CARE UNIT	2,972	0	0	132		31.00
43.00	04300	NURSERY	1,399	0	0	200		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,395	383,514	0	2,449		50.00
51.00	05100	RECOVERY ROOM	21,300	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,899	48,126	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	39,587	0	19,347		54.00
60.00	06000	LABORATORY	0	831,036	0	26,791		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	26,850	0	2,488		65.00
65.01	06501	SLEEP LAB	0	0	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	8,462	0	8,293		66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,936	0	4,675		69.00
69.01	06901	CARDIAC REHAB	0	1,500	0	2,991		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,199,503	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	305,263	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	18	0	213		76.00
76.01	03480	ONCOLOGY	0	624	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000	CLINIC	5,372	16,701	0	3,713		90.00
91.00	09100	EMERGENCY	57,333	133,439	0	14,972		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	9,937	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	2,322	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	205,243	3,152,014	100	87,337		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0		194.00
194.01	07951	MOB	0	655	0	0		194.01
194.02	07952	COMMUNITY HEALTH	0	3,015	0	0		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0		194.03
194.04	07954	EDUCATION	0	0	0	0		194.04
194.05	07955	MARKETING	0	1,397	0	0		194.05
194.06	07956	GUEST MEALS	0	0	0	0		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0	0		194.08
194.09	07959	URGENT CARE	0	22,553	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)	1,393,281	541,259	2,804,994	943,849		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.788446	0.170227	28,049.940000	10.806978		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	55,301	156,088	77,693	39,673		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.269442	0.049090	776.930000	0.454252		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 9/6/2016 3:17 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,928,641		6,928,641	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	359,450		359,450	0	0	31.00
43.00	04300	NURSERY	235,374		235,374	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,909,577		3,909,577	0	0	50.00
51.00	05100	RECOVERY ROOM	1,948,934		1,948,934	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	792,447		792,447	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,998,728		3,998,728	0	0	54.00
60.00	06000	LABORATORY	4,215,047		4,215,047	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	977,255	0	977,255	0	0	65.00
65.01	06501	SLEEP LAB	441,697	0	441,697	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,844,121	0	1,844,121	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	427,012		427,012	0	0	69.00
69.01	06901	CARDIAC REHAB	317,362		317,362	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,626,219		1,626,219	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	535,860		535,860	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,804,994		2,804,994	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	87,814		87,814	0	0	76.00
76.01	03480	ONCOLOGY	3,427,669		3,427,669	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	400,221		400,221	0	0	90.00
91.00	09100	EMERGENCY	4,621,558		4,621,558	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,168,591		1,168,591		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,212,404		1,212,404		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	285,409		285,409		0	116.00
200.00		Subtotal (see instructions)	42,566,384	0	42,566,384	0	0	200.00
201.00		Less Observation Beds	1,168,591		1,168,591		0	201.00
202.00		Total (see instructions)	41,397,793	0	41,397,793	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 9/6/2016 3:17 pm

Title XVIII | 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	5,910,589		5,910,589			30.00
31.00	03100	INTENSIVE CARE UNIT	422,562		422,562			31.00
43.00	04300	NURSERY	361,120		361,120			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,469,869	7,460,614	8,930,483	0.437779	0.000000	50.00
51.00	05100	RECOVERY ROOM	293,845	1,633,975	1,927,820	1.010952	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	342,370	479,183	821,553	0.964572	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,300,707	25,500,833	26,801,540	0.149198	0.000000	54.00
60.00	06000	LABORATORY	2,130,767	11,806,970	13,937,737	0.302420	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,000,900	572,922	1,573,822	0.620944	0.000000	65.00
65.01	06501	SLEEP LAB	0	837,343	837,343	0.527498	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	733,511	2,218,370	2,951,881	0.624727	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	107,174	1,207,313	1,314,487	0.324851	0.000000	69.00
69.01	06901	CARDIAC REHAB	17,772	310,593	328,365	0.966492	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	769,350	1,663,296	2,432,646	0.668498	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	393,524	518,690	912,214	0.587428	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,264,530	5,145,331	6,409,861	0.437606	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	24,399	24,399	3.599082	0.000000	76.00
76.01	03480	ONCOLOGY	2,698	7,604,940	7,607,638	0.450556	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	78	473,632	473,710	0.844865	0.000000	90.00
91.00	09100	EMERGENCY	540,605	11,949,625	12,490,230	0.370014	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	233,339	786,878	1,020,217	1.145434	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,110,825	1,110,825			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	471,051	471,051			116.00
200.00		Subtotal (see instructions)	17,295,310	81,776,783	99,072,093			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,295,310	81,776,783	99,072,093			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 9/6/2016 3:17 pm

Title XVIII | 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	06501	SLEEP LAB	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHAB	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000		76.00
76.01	03480	ONCOLOGY	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 9/6/2016 3:17 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,928,641		6,928,641	0	6,928,641	30.00
31.00	03100	INTENSIVE CARE UNIT	359,450		359,450	0	359,450	31.00
43.00	04300	NURSERY	235,374		235,374	0	235,374	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,909,577		3,909,577	0	3,909,577	50.00
51.00	05100	RECOVERY ROOM	1,948,934		1,948,934	0	1,948,934	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	792,447		792,447	0	792,447	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,998,728		3,998,728	0	3,998,728	54.00
60.00	06000	LABORATORY	4,215,047		4,215,047	0	4,215,047	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	977,255	0	977,255	0	977,255	65.00
65.01	06501	SLEEP LAB	441,697	0	441,697	0	441,697	65.01
66.00	06600	PHYSICAL THERAPY	1,844,121	0	1,844,121	0	1,844,121	66.00
69.00	06900	ELECTROCARDIOLOGY	427,012		427,012	0	427,012	69.00
69.01	06901	CARDIAC REHAB	317,362		317,362	0	317,362	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,626,219		1,626,219	0	1,626,219	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	535,860		535,860	0	535,860	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,804,994		2,804,994	0	2,804,994	73.00
76.00	03020	CHEMICAL DEPENDENCY	87,814		87,814	0	87,814	76.00
76.01	03480	ONCOLOGY	3,427,669		3,427,669	0	3,427,669	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	400,221		400,221	0	400,221	90.00
91.00	09100	EMERGENCY	4,621,558		4,621,558	0	4,621,558	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,168,591		1,168,591		1,168,591	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,212,404		1,212,404		1,212,404	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	285,409		285,409		285,409	116.00
200.00		Subtotal (see instructions)	42,566,384	0	42,566,384	0	42,566,384	200.00
201.00		Less Observation Beds	1,168,591		1,168,591		1,168,591	201.00
202.00		Total (see instructions)	41,397,793	0	41,397,793	0	41,397,793	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 9/6/2016 3:17 pm

Title XIX | Hospital | PPS

		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	5,910,589		5,910,589			30.00
31.00	03100	INTENSIVE CARE UNIT	422,562		422,562			31.00
43.00	04300	NURSERY	361,120		361,120			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,469,869	7,460,614	8,930,483	0.437779	0.000000	50.00
51.00	05100	RECOVERY ROOM	293,845	1,633,975	1,927,820	1.010952	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	342,370	479,183	821,553	0.964572	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,300,707	25,500,833	26,801,540	0.149198	0.000000	54.00
60.00	06000	LABORATORY	2,130,767	11,806,970	13,937,737	0.302420	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,000,900	572,922	1,573,822	0.620944	0.000000	65.00
65.01	06501	SLEEP LAB	0	837,343	837,343	0.527498	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	733,511	2,218,370	2,951,881	0.624727	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	107,174	1,207,313	1,314,487	0.324851	0.000000	69.00
69.01	06901	CARDIAC REHAB	17,772	310,593	328,365	0.966492	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	769,350	1,663,296	2,432,646	0.668498	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	393,524	518,690	912,214	0.587428	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,264,530	5,145,331	6,409,861	0.437606	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	24,399	24,399	3.599082	0.000000	76.00
76.01	03480	ONCOLOGY	2,698	7,604,940	7,607,638	0.450556	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	78	473,632	473,710	0.844865	0.000000	90.00
91.00	09100	EMERGENCY	540,605	11,949,625	12,490,230	0.370014	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	233,339	786,878	1,020,217	1.145434	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,110,825	1,110,825			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	471,051	471,051			116.00
200.00		Subtotal (see instructions)	17,295,310	81,776,783	99,072,093			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,295,310	81,776,783	99,072,093			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 9/6/2016 3:17 pm

Title XIX | 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
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.437779	50.00
51.00	05100	RECOVERY ROOM	1.010952	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.964572	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149198	54.00
60.00	06000	LABORATORY	0.302420	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.620944	65.00
65.01	06501	SLEEP LAB	0.527498	65.01
66.00	06600	PHYSICAL THERAPY	0.624727	66.00
69.00	06900	ELECTROCARDIOLOGY	0.324851	69.00
69.01	06901	CARDIAC REHAB	0.966492	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.668498	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.587428	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437606	73.00
76.00	03020	CHEMICAL DEPENDENCY	3.599082	76.00
76.01	03480	ONCOLOGY	0.450556	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
90.00	09000	CLINIC	0.844865	90.00
91.00	09100	EMERGENCY	0.370014	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.145434	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part II Date/Time Prepared: 9/6/2016 3:17 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,909,577	593,562	3,316,015	0	0	50.00
51.00	05100	RECOVERY ROOM	1,948,934	365,618	1,583,316	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	792,447	169,271	623,176	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,998,728	421,512	3,577,216	0	0	54.00
60.00	06000	LABORATORY	4,215,047	223,431	3,991,616	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	977,255	46,273	930,982	0	0	65.00
65.01	06501	SLEEP LAB	441,697	72,084	369,613	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,844,121	293,006	1,551,115	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	427,012	11,578	415,434	0	0	69.00
69.01	06901	CARDIAC REHAB	317,362	62,424	254,938	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,626,219	68,111	1,558,108	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	535,860	18,125	517,735	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,804,994	77,693	2,727,301	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	87,814	12,032	75,782	0	0	76.00
76.01	03480	ONCOLOGY	3,427,669	555,520	2,872,149	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	400,221	39,784	360,437	0	0	90.00
91.00	09100	EMERGENCY	4,621,558	414,882	4,206,676	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,168,591	173,605	994,986	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,212,404	52,355	1,160,049	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	285,409	11,249	274,160	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	35,042,919	3,682,115	31,360,804	0	0	200.00
201.00		Less Observation Beds	1,168,591	173,605	994,986	0	0	201.00
202.00		Total (line 200 minus line 201)	33,874,328	3,508,510	30,365,818	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part II Date/Time Prepared: 9/6/2016 3:17 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,909,577	8,930,483	0.437779		50.00
51.00	05100	RECOVERY ROOM	1,948,934	1,927,820	1.010952		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	792,447	821,553	0.964572		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,998,728	26,801,540	0.149198		54.00
60.00	06000	LABORATORY	4,215,047	13,937,737	0.302420		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	977,255	1,573,822	0.620944		65.00
65.01	06501	SLEEP LAB	441,697	837,343	0.527498		65.01
66.00	06600	PHYSICAL THERAPY	1,844,121	2,951,881	0.624727		66.00
69.00	06900	ELECTROCARDIOLOGY	427,012	1,314,487	0.324851		69.00
69.01	06901	CARDIAC REHAB	317,362	328,365	0.966492		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,626,219	2,432,646	0.668498		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	535,860	912,214	0.587428		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,804,994	6,409,861	0.437606		73.00
76.00	03020	CHEMICAL DEPENDENCY	87,814	24,399	3.599082		76.00
76.01	03480	ONCOLOGY	3,427,669	7,607,638	0.450556		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	09000	CLINIC	400,221	473,710	0.844865		90.00
91.00	09100	EMERGENCY	4,621,558	12,490,230	0.370014		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,168,591	1,020,217	1.145434		92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	1,212,404	1,110,825	1.091445		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	285,409	471,051	0.605898		116.00
200.00		Subtotal (sum of lines 50 thru 199)	35,042,919	92,377,822			200.00
201.00		Less Observation Beds	1,168,591	0			201.00
202.00		Total (line 200 minus line 201)	33,874,328	92,377,822			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 9/6/2016 3:17 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	593,562	8,930,483	0.066465	420,515	27,950	50.00
51.00	05100	RECOVERY ROOM	365,618	1,927,820	0.189654	80,278	15,225	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	169,271	821,553	0.206038	3,103	639	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	421,512	26,801,540	0.015727	458,042	7,204	54.00
60.00	06000	LABORATORY	223,431	13,937,737	0.016031	828,892	13,288	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	46,273	1,573,822	0.029402	413,779	12,166	65.00
65.01	06501	SLEEP LAB	72,084	837,343	0.086087	0	0	65.01
66.00	06600	PHYSICAL THERAPY	293,006	2,951,881	0.099261	174,405	17,312	66.00
69.00	06900	ELECTROCARDIOLOGY	11,578	1,314,487	0.008808	47,116	415	69.00
69.01	06901	CARDIAC REHAB	62,424	328,365	0.190106	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68,111	2,432,646	0.027999	282,476	7,909	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,125	912,214	0.019869	132,469	2,632	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,693	6,409,861	0.012121	464,738	5,633	73.00
76.00	03020	CHEMICAL DEPENDENCY	12,032	24,399	0.493135	0	0	76.00
76.01	03480	ONCOLOGY	555,520	7,607,638	0.073021	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	39,784	473,710	0.083984	74	6	90.00
91.00	09100	EMERGENCY	414,882	12,490,230	0.033217	5,920	197	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	173,605	1,020,217	0.170165	211,053	35,914	92.00
200.00		Total (lines 50-199)	3,618,511	90,795,946		3,522,860	146,490	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 9/6/2016 3:17 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
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	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 9/6/2016 3:17 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	8,930,483	0.000000	0.000000	420,515	50.00
51.00	05100	RECOVERY ROOM	0	1,927,820	0.000000	0.000000	80,278	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	821,553	0.000000	0.000000	3,103	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,801,540	0.000000	0.000000	458,042	54.00
60.00	06000	LABORATORY	0	13,937,737	0.000000	0.000000	828,892	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,573,822	0.000000	0.000000	413,779	65.00
65.01	06501	SLEEP LAB	0	837,343	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	2,951,881	0.000000	0.000000	174,405	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,314,487	0.000000	0.000000	47,116	69.00
69.01	06901	CARDIAC REHAB	0	328,365	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,432,646	0.000000	0.000000	282,476	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	912,214	0.000000	0.000000	132,469	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,409,861	0.000000	0.000000	464,738	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	24,399	0.000000	0.000000	0	76.00
76.01	03480	ONCOLOGY	0	7,607,638	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	473,710	0.000000	0.000000	74	90.00
91.00	09100	EMERGENCY	0	12,490,230	0.000000	0.000000	5,920	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,020,217	0.000000	0.000000	211,053	92.00
200.00		Total (lines 50-199)	0	90,795,946			3,522,860	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 9/6/2016 3:17 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
65.01	06501	SLEEP LAB	0	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0		76.00
76.01	03480	ONCOLOGY	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 9/6/2016 3:17 pm

Title XVIII | 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	0.437779	0	1,846,590	0	0	50.00
51.00	05100	RECOVERY ROOM	1.010952	0	337,232	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.964572	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149198	0	5,939,153	0	0	54.00
60.00	06000	LABORATORY	0.302420	0	3,456,673	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.620944	0	386,232	0	0	65.00
65.01	06501	SLEEP LAB	0.527498	0	2,981	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.624727	0	749,574	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.324851	0	359,939	0	0	69.00
69.01	06901	CARDIAC REHAB	0.966492	0	108,012	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.668498	0	367,278	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.587428	0	147,864	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437606	0	1,564,553	5,733	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	3.599082	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.450556	0	1,605,869	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.844865	0	240,206	0	0	90.00
91.00	09100	EMERGENCY	0.370014	0	2,504,972	2,022	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.145434	0	482,273	2,359	0	92.00
200.00		Subtotal (see instructions)		0	20,099,401	10,114	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	20,099,401	10,114	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 9/6/2016 3:17 pm

Title XVIII | 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	808,398	0		50.00
51.00	05100	RECOVERY ROOM	340,925	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	886,110	0		54.00
60.00	06000	LABORATORY	1,045,367	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	239,828	0		65.00
65.01	06501	SLEEP LAB	1,572	0		65.01
66.00	06600	PHYSICAL THERAPY	468,279	0		66.00
69.00	06900	ELECTROCARDIOLOGY	116,927	0		69.00
69.01	06901	CARDIAC REHAB	104,393	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	245,525	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	86,859	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	684,658	2,509		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0		76.00
76.01	03480	ONCOLOGY	723,534	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	202,942	0		90.00
91.00	09100	EMERGENCY	926,875	748		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	552,412	2,702		92.00
200.00		Subtotal (see instructions)	7,434,604	5,959		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	7,434,604	5,959		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151315 | Component CCN: 15Z315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 9/6/2016 3:17 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.437779	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	1.010952	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.964572	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149198	0	0	0	0	54.00
60.00	06000	LABORATORY	0.302420	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.620944	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0.527498	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.624727	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.324851	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.966492	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.668498	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.587428	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437606	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	3.599082	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.450556	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.844865	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.370014	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.145434	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151315 | Component CCN: 15Z315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V | Date/Time Prepared: 9/6/2016 3:17 pm

Title XVIII | Swing Beds - SNF | 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	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
65.01	06501	SLEEP LAB	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	76.00
76.01	03480	ONCOLOGY	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part I | Date/Time Prepared: 9/6/2016 3:17 pm

Title XIX | 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	1,029,313	72,079	957,234	4,024	237.88	30.00
31.00	INTENSIVE CARE UNIT	70,984		70,984	180	394.36	31.00
43.00	NURSERY	26,478		26,478	434	61.01	43.00
200.00	Total (lines 30-199)	1,126,775		1,054,696	4,638		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	108	25,691	30.00
31.00	INTENSIVE CARE UNIT	26	10,253	31.00
43.00	NURSERY	34	2,074	43.00
200.00	Total (lines 30-199)	168	38,018	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 9/6/2016 3:17 pm

Title XIX | 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	593,562	8,930,483	0.066465	47,416	3,152	50.00
51.00	05100	RECOVERY ROOM	365,618	1,927,820	0.189654	9,479	1,798	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	169,271	821,553	0.206038	11,044	2,275	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	421,512	26,801,540	0.015727	41,959	660	54.00
60.00	06000	LABORATORY	223,431	13,937,737	0.016031	68,736	1,102	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	46,273	1,573,822	0.029402	32,288	949	65.00
65.01	06501	SLEEP LAB	72,084	837,343	0.086087	0	0	65.01
66.00	06600	PHYSICAL THERAPY	293,006	2,951,881	0.099261	23,662	2,349	66.00
69.00	06900	ELECTROCARDIOLOGY	11,578	1,314,487	0.008808	3,457	30	69.00
69.01	06901	CARDIAC REHAB	62,424	328,365	0.190106	573	109	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68,111	2,432,646	0.027999	37,513	1,050	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,125	912,214	0.019869	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,693	6,409,861	0.012121	40,792	494	73.00
76.00	03020	CHEMICAL DEPENDENCY	12,032	24,399	0.493135	0	0	76.00
76.01	03480	ONCOLOGY	555,520	7,607,638	0.073021	87	6	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	39,784	473,710	0.083984	2	0	90.00
91.00	09100	EMERGENCY	414,882	12,490,230	0.033217	17,439	579	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	174,843	1,020,217	0.171378	18,552	3,179	92.00
200.00		Total (lines 50-199)	3,619,749	90,795,946		352,999	17,732	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part III Date/Time Prepared: 9/6/2016 3:17 pm

Title XIX | 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
43.00	04300	NURSERY	0	0	0		0	43.00
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	4,024	0.00	108	0		30.00
31.00	03100	INTENSIVE CARE UNIT	180	0.00	26	0		31.00
43.00	04300	NURSERY	434	0.00	34	0		43.00
200.00		Total (lines 30-199)	4,638		168	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 9/6/2016 3:17 pm

Title XIX | 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
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	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 9/6/2016 3:17 pm

Title XIX | 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	8,930,483	0.000000	0.000000	47,416	50.00
51.00	05100	RECOVERY ROOM	0	1,927,820	0.000000	0.000000	9,479	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	821,553	0.000000	0.000000	11,044	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,801,540	0.000000	0.000000	41,959	54.00
60.00	06000	LABORATORY	0	13,937,737	0.000000	0.000000	68,736	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,573,822	0.000000	0.000000	32,288	65.00
65.01	06501	SLEEP LAB	0	837,343	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	2,951,881	0.000000	0.000000	23,662	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,314,487	0.000000	0.000000	3,457	69.00
69.01	06901	CARDIAC REHAB	0	328,365	0.000000	0.000000	573	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,432,646	0.000000	0.000000	37,513	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	912,214	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,409,861	0.000000	0.000000	40,792	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	24,399	0.000000	0.000000	0	76.00
76.01	03480	ONCOLOGY	0	7,607,638	0.000000	0.000000	87	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	473,710	0.000000	0.000000	2	90.00
91.00	09100	EMERGENCY	0	12,490,230	0.000000	0.000000	17,439	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,020,217	0.000000	0.000000	18,552	92.00
200.00		Total (lines 50-199)	0	90,795,946			352,999	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 9/6/2016 3:17 pm

Title XIX | 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	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
65.01	06501	SLEEP LAB	0	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0		76.00
76.01	03480	ONCOLOGY	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/6/2016 3:17 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,707	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,024	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,289	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)	303	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)	380	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,171	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)	303	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,928,641	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)	49,073	25.00
26.00	Total swing-bed cost (see instructions)	530,819	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,397,822	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)	6,397,822	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)	1,589.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,861,796	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,861,796	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/6/2016 3:17 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	359,450	180	1,996.94	69	137,789	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)	1,682,475	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,682,060	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	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)	481,746	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	481,746	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)	735	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,589.92	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,168,591	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/6/2016 3:17 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,029,313	6,928,641	0.148559	1,168,591	173,605	90.00
91.00	Nursing School cost	0	6,928,641	0.000000	1,168,591	0	91.00
92.00	Allied health cost	0	6,928,641	0.000000	1,168,591	0	92.00
93.00	All other Medical Education	0	6,928,641	0.000000	1,168,591	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/6/2016 3:17 pm

Title XIX | 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)	4,707	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,024	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,289	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)	303	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)	380	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	108	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)	434	15.00
16.00	Nursery days (title V or XIX only)	34	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	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)	6,928,641	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)	485,182	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,443,459	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)	6,443,459	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)	1,601.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	172,936	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)	172,936	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/6/2016 3:17 pm

Title XIX | 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)	235,374	434	542.34	34	18,440	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	359,450	180	1,996.94	26	51,920	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)	175,221	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	418,517	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)	38,018	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	17,732	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	55,750	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	362,767	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)	735	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,601.26	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,176,926	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/6/2016 3:17 pm

Title XIX | 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	1,029,313	6,928,641	0.148559	1,176,926	174,843	90.00
91.00	Nursing School cost	0	6,928,641	0.000000	1,176,926	0	91.00
92.00	Allied health cost	0	6,928,641	0.000000	1,176,926	0	92.00
93.00	All other Medical Education	0	6,928,641	0.000000	1,176,926	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 9/6/2016 3:17 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,515,800		30.00
31.00	03100	INTENSIVE CARE UNIT		143,520		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.437779	420,515	184,093	50.00
51.00	05100	RECOVERY ROOM	1.010952	80,278	81,157	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.964572	3,103	2,993	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149198	458,042	68,339	54.00
60.00	06000	LABORATORY	0.302420	828,892	250,674	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.620944	413,779	256,934	65.00
65.01	06501	SLEEP LAB	0.527498	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.624727	174,405	108,956	66.00
69.00	06900	ELECTROCARDIOLOGY	0.324851	47,116	15,306	69.00
69.01	06901	CARDIAC REHAB	0.966492	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.668498	282,476	188,835	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.587428	132,469	77,816	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437606	464,738	203,372	73.00
76.00	03020	CHEMICAL DEPENDENCY	3.599082	0	0	76.00
76.01	03480	ONCOLOGY	0.450556	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.844865	74	63	90.00
91.00	09100	EMERGENCY	0.370014	5,920	2,190	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.145434	211,053	241,747	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,522,860	1,682,475	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)		3,522,860		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3

Component CCN: 15Z315 | Date/Time Prepared: 9/6/2016 3:17 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.437779	3,163	1,385	50.00
51.00	05100	RECOVERY ROOM	1.010952	189	191	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.964572	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149198	11,943	1,782	54.00
60.00	06000	LABORATORY	0.302420	27,739	8,389	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.620944	39,091	24,273	65.00
65.01	06501	SLEEP LAB	0.527498	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.624727	167,617	104,715	66.00
69.00	06900	ELECTROCARDIOLOGY	0.324851	693	225	69.00
69.01	06901	CARDIAC REHAB	0.966492	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.668498	13,645	9,122	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.587428	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437606	54,934	24,039	73.00
76.00	03020	CHEMICAL DEPENDENCY	3.599082	0	0	76.00
76.01	03480	ONCOLOGY	0.450556	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.844865	0	0	90.00
91.00	09100	EMERGENCY	0.370014	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.145434	3,616	4,142	92.00
200.00		Total (sum of lines 50-94 and 96-98)		322,630	178,263	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)		322,630		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 9/6/2016 3:17 pm

Title XIX | 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		158,687		30.00
31.00	03100	INTENSIVE CARE UNIT		13,631		31.00
43.00	04300	NURSERY		11,649		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.437779	47,416	20,758	50.00
51.00	05100	RECOVERY ROOM	1.010952	9,479	9,583	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.964572	11,044	10,653	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149198	41,959	6,260	54.00
60.00	06000	LABORATORY	0.302420	68,736	20,787	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.620944	32,288	20,049	65.00
65.01	06501	SLEEP LAB	0.527498	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.624727	23,662	14,782	66.00
69.00	06900	ELECTROCARDIOLOGY	0.324851	3,457	1,123	69.00
69.01	06901	CARDIAC REHAB	0.966492	573	554	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.668498	37,513	25,077	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.587428	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437606	40,792	17,851	73.00
76.00	03020	CHEMICAL DEPENDENCY	3.599082	0	0	76.00
76.01	03480	ONCOLOGY	0.450556	87	39	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.844865	2	2	90.00
91.00	09100	EMERGENCY	0.370014	17,439	6,453	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.145434	18,552	21,250	92.00
200.00		Total (sum of lines 50-94 and 96-98)		352,999	175,221	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)		352,999		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 9/6/2016 3:17 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,440,563	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,440,563	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	7,514,969	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)	33,042	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,323,909	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)	4,158,018	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)	4,158,018	30.00
31.00	Primary payer payments	287	31.00
32.00	Subtotal (line 30 minus line 31)	4,157,731	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)	533,037	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	346,474	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	413,001	36.00
37.00	Subtotal (see instructions)	4,504,205	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)	4,504,205	40.00
40.01	Sequestration adjustment (see instructions)	90,084	40.01
41.00	Interim payments	4,394,106	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	20,015	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I Date/Time Prepared: 9/6/2016 3:17 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,605,137		4,394,106	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)		2,605,137		4,394,106	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		656,849		20,015	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,261,986		4,414,121	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: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 9/6/2016 3:17 pm

Component CCN: 15Z315 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		520,239		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		520,239		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		132,144		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		652,383		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet E-1 Part II Date/Time Prepared: 9/6/2016 3:17 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,306	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,240	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	634	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	3,469	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	99,072,093	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,049,080	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 151315 | Component CCN: 15Z315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-2 | Date/Time Prepared: 9/6/2016 3:17 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	486,563	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	180,046	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	303	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	666,609	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	666,609	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	666,609	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	912	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	665,697	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	665,697	0	19.00
19.01	Sequestration adjustment (see instructions)	13,314	0	19.01
20.00	Interim payments	520,239	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	132,144	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part V Date/Time Prepared: 9/6/2016 3:17 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,682,060	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,682,060	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,718,881	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,718,881	19.00
20.00	Deductibles (exclude professional component)	411,972	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,306,909	22.00
23.00	Coinsurance	1,249	23.00
24.00	Subtotal (line 22 minus line 23)	3,305,660	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	35,226	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	22,897	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	16,698	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,328,557	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	3,328,557	30.00
30.01	Sequestration adjustment (see instructions)	66,571	30.01
31.00	Interim payments	2,605,137	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	656,849	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-3 Part VII Date/Time Prepared: 9/6/2016 3:17 pm

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	183,968		8.00
9.00	Ancillary service charges	352,999	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	536,967	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	536,967	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	536,967	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	318,202	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-318,202	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G | Date/Time Prepared: 9/6/2016 3:17 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	1,827,133	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	216,225	0	0	0	3.00
4.00	Accounts receivable	8,504,724	0	0	0	4.00
5.00	Other receivable	748,342	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	853,493	0	0	0	7.00
8.00	Prepaid expenses	789,430	0	0	0	8.00
9.00	Other current assets	2,245,773	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)	15,185,120	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,317,868	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	52,431,702	0	0	0	15.00
16.00	Accumulated depreciation	-5,885,654	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	15,279,796	0	0	0	23.00
24.00	Accumulated depreciation	-7,726,426	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)	55,417,286	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	19,014,955	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	1,443,554	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	20,458,509	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	91,060,915	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,038,771	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,101,064	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	800,970	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,476,535	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,417,340	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	47,060,254	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	47,060,254	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	53,477,594	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	37,583,321				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)	37,583,321	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	91,060,915	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-1 | Date/Time Prepared: 9/6/2016 3:17 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		37,292,266		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		40,630				2.00
3.00	Total (sum of line 1 and line 2)		37,332,896		0		3.00
4.00	NA RELEASED FROM RESTRICTION	346,635		0		0	4.00
5.00	CONTRIBUTIONS	262,296		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)		608,931		0		10.00
11.00	Subtotal (line 3 plus line 10)		37,941,827		0		11.00
12.00	INVESTMENT LOSS	6,126		0		0	12.00
13.00	NA RELEASED FROM RESTRICTION	352,380		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)		358,506		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		37,583,321		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	NA RELEASED FROM RESTRICTION		0			4.00
5.00	CONTRIBUTIONS		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	INVESTMENT LOSS		0			12.00
13.00	NA RELEASED FROM RESTRICTION		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: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 9/6/2016 3:17 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,271,709		6,271,709	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				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)	6,271,709		6,271,709	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	422,562		422,562	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)	422,562		422,562	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,694,271		6,694,271	17.00
18.00	Ancillary services	10,457,035	66,984,772	77,441,807	18.00
19.00	Outpatient services	0	13,354,139	13,354,139	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,110,825	1,110,825	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	471,051	471,051	26.00
27.00	OTHER	0	5,087,308	5,087,308	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	17,151,306	87,008,095	104,159,401	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		48,732,073		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)		48,732,073		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet G-3 Date/Time Prepared: 9/6/2016 3:17 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	104,159,401	1.00
2.00	Less contractual allowances and discounts on patients' accounts	55,599,180	2.00
3.00	Net patient revenues (line 1 minus line 2)	48,560,221	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	48,732,073	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-171,852	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	212,482	24.00
25.00	Total other income (sum of lines 6-24)	212,482	25.00
26.00	Total (line 5 plus line 25)	40,630	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)	40,630	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151315 | HHA CCN: 157117 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H | Date/Time Prepared: 9/6/2016 3:17 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	183,219	0	0	12,110	52,100	247,429	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	252,517	0	33,148	0	0	285,665	6.00
7.00	Physical Therapy	153,409	0	0	0	0	153,409	7.00
8.00	Occupational Therapy	28,531	0	0	0	0	28,531	8.00
9.00	Speech Pathology	3,245	0	0	0	0	3,245	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	47,242	0	0	0	0	47,242	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)	668,163	0	33,148	12,110	52,100	765,521	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	-103,546	143,883	0	143,883			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	285,665	0	285,665			6.00
7.00	Physical Therapy	0	153,409	0	153,409			7.00
8.00	Occupational Therapy	0	28,531	0	28,531			8.00
9.00	Speech Pathology	0	3,245	0	3,245			9.00
10.00	Medical Social Services	7,225	7,225	0	7,225			10.00
11.00	Home Health Aide	0	47,242	0	47,242			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)	-96,321	669,200	0	669,200			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: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-1 Part I

HHA CCN: 157117 | Date/Time Prepared: 9/6/2016 3:17 pm

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	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	143,883	0	0	0	0	143,883	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	285,665	0	0	0	0	285,665	6.00
7.00	Physical Therapy	153,409	0	0	0	0	153,409	7.00
8.00	Occupational Therapy	28,531	0	0	0	0	28,531	8.00
9.00	Speech Pathology	3,245	0	0	0	0	3,245	9.00
10.00	Medical Social Services	7,225	0	0	0	0	7,225	10.00
11.00	Home Health Aide	47,242	0	0	0	0	47,242	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)	669,200	0	0	0	0	669,200	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	143,883		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	78,243	363,908	6.00
7.00	Physical Therapy	42,018	195,427	7.00
8.00	Occupational Therapy	7,815	36,346	8.00
9.00	Speech Pathology	889	4,134	9.00
10.00	Medical Social Services	1,979	9,204	10.00
11.00	Home Health Aide	12,939	60,181	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)		669,200	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 151315 | HHA CCN: 157117 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-1 Part II | Date/Time Prepared: 9/6/2016 3:17 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	-143,883	525,317	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	285,665	6.00
7.00	Physical Therapy	0	0	0	0	0	153,409	7.00
8.00	Occupational Therapy	0	0	0	0	0	28,531	8.00
9.00	Speech Pathology	0	0	0	0	0	3,245	9.00
10.00	Medical Social Services	0	0	0	0	0	7,225	10.00
11.00	Home Health Aide	0	0	0	0	0	47,242	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	-143,883	525,317	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		143,883	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.273897	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151315 HHA CCN: 157117 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-2 Part I Date/Time Prepared: 9/6/2016 3:17 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	0	31,321	171,887	203,208	53,948	1.00
2.00	Skilled Nursing Care	363,908	0	0	0	363,908	96,611	2.00
3.00	Physical Therapy	195,427	0	0	0	195,427	51,883	3.00
4.00	Occupational Therapy	36,346	0	0	0	36,346	9,649	4.00
5.00	Speech Pathology	4,134	0	0	0	4,134	1,098	5.00
6.00	Medical Social Services	9,204	0	0	0	9,204	2,444	6.00
7.00	Home Health Aide	60,181	0	0	0	60,181	15,977	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)	669,200	0	31,321	171,887	872,408	231,610	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	59,022	219	6,219	0	41,234	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	59,022	219	6,219	0	41,234	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: 151315 | HHA CCN: 157117 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-2 Part I | Date/Time Prepared: 9/6/2016 3:17 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	1,692	0	0	365,542	0	365,542	1.00
2.00	Skilled Nursing Care	0	0	0	460,519	0	460,519	2.00
3.00	Physical Therapy	0	0	0	247,310	0	247,310	3.00
4.00	Occupational Therapy	0	0	0	45,995	0	45,995	4.00
5.00	Speech Pathology	0	0	0	5,232	0	5,232	5.00
6.00	Medical Social Services	0	0	0	11,648	0	11,648	6.00
7.00	Home Health Aide	0	0	0	76,158	0	76,158	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)	1,692	0	0	1,212,404	0	1,212,404	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	198,780	659,299	2.00
3.00	Physical Therapy	106,750	354,060	3.00
4.00	Occupational Therapy	19,853	65,848	4.00
5.00	Speech Pathology	2,258	7,490	5.00
6.00	Medical Social Services	5,028	16,676	6.00
7.00	Home Health Aide	32,873	109,031	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)	365,542	1,212,404	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.	0.431643		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: 151315 HHA CCN: 157117 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-2 Part II Date/Time Prepared: 9/6/2016 3:17 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)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	0	1,469	571,841	0	203,208	1,469	1.00
2.00	Skilled Nursing Care	0	0	0	0	363,908	0	2.00
3.00	Physical Therapy	0	0	0	0	195,427	0	3.00
4.00	Occupational Therapy	0	0	0	0	36,346	0	4.00
5.00	Speech Pathology	0	0	0	0	4,134	0	5.00
6.00	Medical Social Services	0	0	0	0	9,204	0	6.00
7.00	Home Health Aide	0	0	0	0	60,181	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	1,469	571,841		872,408	1,469	20.00
21.00	Total cost to be allocated	0	31,321	171,887		231,610	59,022	21.00
22.00	Unit cost multiplier	0.000000	21.321307	0.300585		0.265484	40.178353	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	35	19	0	909	0	9,937	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	35	19	0	909	0	9,937	20.00
21.00	Total cost to be allocated	219	6,219	0	41,234	0	1,692	21.00
22.00	Unit cost multiplier	6.257143	327.315789	0.000000	45.361936	0.000000	0.170273	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151315 | HHA CCN: 157117 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-2 Part II | Date/Time Prepared: 9/6/2016 3:17 pm

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-3 Part I | Date/Time Prepared: 9/6/2016 3:17 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	659,299		659,299	2,121	310.84	1.00
2.00	Physical Therapy	3.00	354,060	0	354,060	2,163	163.69	2.00
3.00	Occupational Therapy	4.00	65,848	0	65,848	442	148.98	3.00
4.00	Speech Pathology	5.00	7,490	0	7,490	59	126.95	4.00
5.00	Medical Social Services	6.00	16,676		16,676	70	238.23	5.00
6.00	Home Health Aide	7.00	109,031		109,031	2,538	42.96	6.00
7.00	Total (sum of lines 1-6)		1,212,404	0	1,212,404	7,393		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		99915	0	269			8.00
8.01	Skilled Nursing Care		50031	0	539			8.01
9.00	Physical Therapy		99915	0	324			9.00
9.01	Physical Therapy		50031	0	500			9.01
10.00	Occupational Therapy		99915	0	49			10.00
10.01	Occupational Therapy		50031	0	41			10.01
11.00	Speech Pathology		99915	0	6			11.00
11.01	Speech Pathology		50031	0	19			11.01
12.00	Medical Social Services		99915	0	6			12.00
12.01	Medical Social Services		50031	0	9			12.01
13.00	Home Health Aide		99915	0	120			13.00
13.01	Home Health Aide		50031	0	148			13.01
14.00	Total (sum of lines 8-13)			0	2,030			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	Part B Not Subject to Deductibles & Coinsurance	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	808		0	251,159		1.00
2.00	Physical Therapy	0	824		0	134,881		2.00
3.00	Occupational Therapy	0	90		0	13,408		3.00
4.00	Speech Pathology	0	25		0	3,174		4.00
5.00	Medical Social Services	0	15		0	3,573		5.00
6.00	Home Health Aide	0	268		0	11,513		6.00
7.00	Total (sum of lines 1-6)	0	2,030		0	417,708		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-3 Part I | Date/Time Prepared: 9/6/2016 3:17 pm

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		550	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	251,159						1.00
2.00	Physical Therapy	134,881						2.00
3.00	Occupational Therapy	13,408						3.00
4.00	Speech Pathology	3,174						4.00
5.00	Medical Social Services	3,573						5.00
6.00	Home Health Aide	11,513						6.00
7.00	Total (sum of lines 1-6)	417,708						7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-3 Part II | Date/Time Prepared: 9/6/2016 3:17 pm

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.624727	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	0.668498	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.437606	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 151315 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-4 Part I-II

HHA CCN: 157117 | Date/Time Prepared: 9/6/2016 3:17 pm

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	324,603	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	11,490	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	1,408	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	337,501	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	337,501	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	337,501	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	337,501	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	337,501	31.00
31.01	Sequestration adjustment (see instructions)	0	6,750	31.01
32.00	Interim payments (see instructions)	0	330,751	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: 151315 HHA CCN: 157117 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-5 | Date/Time Prepared: 9/6/2016 3:17 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		330,751	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		330,751	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		330,751	7.00

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

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151315 Hospice CCN: 151561 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K | Date/Time Prepared: 9/6/2016 3:17 pm

Hospice I

		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	21,498	0	0	0	11,535	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	66,420	0	0	2,939	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	23,365	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	37,212	0	0	0	0	15.00
16.00	Spiritual Counseling	7,135	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	132,265	0	23,365	2,939	11,535	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151315 Hospice CCN: 151561 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K | Date/Time Prepared: 9/6/2016 3:17 pm

Hospice I

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	33,033	0	33,033	0	33,033	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	69,359	0	69,359	0	69,359	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	23,365	0	23,365	0	23,365	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	37,212	-7,225	29,987	0	29,987	15.00
16.00	Spiritual Counseling	7,135	0	7,135	0	7,135	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	170,104	-7,225	162,879	0	162,879	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151315 Hospice CCN: 151561

Period: From 10/01/2014 To 09/30/2015

Worksheet K-1

Date/Time Prepared: 9/6/2016 3:17 pm

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	21,498	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	66,420	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	37,212	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	21,498	0	37,212	0	66,420	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151315 Hospice CCN: 151561

Period: From 10/01/2014 To 09/30/2015

Worksheet K-1

Date/Time Prepared: 9/6/2016 3:17 pm

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	21,498		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	66,420		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	0	0		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	37,212		15.00
16.00	Spiritual Counseling		0	7,135	7,135		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	7,135	132,265		39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 151315 Hospice CCN: 151561 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-3 Date/Time Prepared: 9/6/2016 3:17 pm

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	2,939	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	2,939	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES

Provider CCN: 151315 Hospice CCN: 151561

Period: From 10/01/2014 To 09/30/2015

Worksheet K-3

Date/Time Prepared: 9/6/2016 3:17 pm

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	2,939		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	0	0		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	2,939		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151315 Hospice CCN: 151561

Period: From 10/01/2014 To 09/30/2015

Worksheet K-4 Part I Date/Time Prepared: 9/6/2016 3:17 pm

Hospice I

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	33,033	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	69,359	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	23,365	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	29,987	0	0	0	0	15.00
16.00	Spiritual Counseling	7,135	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	162,879	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151315 Hospice CCN: 151561

Period: From 10/01/2014 To 09/30/2015

Worksheet K-4 Part I Date/Time Prepared: 9/6/2016 3:17 pm

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance						3.00
4.00	Transportation - Staff						4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	33,033	33,033			6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	69,359	17,645	87,004		7.00
8.00	Inpatient - Respite Care	0	0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0		9.00
10.00	Nursing Care	0	23,365	5,944	29,309		10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services	0	29,987	7,629	37,616		15.00
16.00	Spiritual Counseling	0	7,135	1,815	8,950		16.00
17.00	Dietary Counseling	0	0	0	0		17.00
18.00	Counseling - Other	0	0	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		20.00
21.00	Other	0	0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0		22.00
23.00	Analgesics	0	0	0	0		23.00
24.00	Sedatives / Hypnotics	0	0	0	0		24.00
25.00	Other - Specify	0	0	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0		26.00
27.00	Patient Transportation	0	0	0	0		27.00
28.00	Imaging Services	0	0	0	0		28.00
29.00	Labs and Diagnostics	0	0	0	0		29.00
30.00	Medical Supplies	0	0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0		31.00
32.00	Radiation Therapy	0	0	0	0		32.00
33.00	Chemotherapy	0	0	0	0		33.00
34.00	Other	0	0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0		35.00
36.00	Volunteer Program Costs	0	0	0	0		36.00
37.00	Fundraising	0	0	0	0		37.00
38.00	Other Program Costs	0	0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	162,879		162,879		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151315 Hospice CCN: 151561 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-4 Part II Date/Time Prepared: 9/6/2016 3:17 pm

Hospice I

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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151315 Hospice CCN: 151561 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-4 Part II Date/Time Prepared: 9/6/2016 3:17 pm

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)		
		6A	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0			1.00
2.00	Capital Related Costs-Movable Equip.	0			2.00
3.00	Plant Operation and Maintenance	0			3.00
4.00	Transportation - Staff	0			4.00
5.00	Volunteer Service Coordination				5.00
6.00	Administrative and General	-33,033	129,846		6.00
	INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	69,359		7.00
8.00	Inpatient - Respite Care	0	0		8.00
	VISITING SERVICES				
9.00	Physician Services	0	0		9.00
10.00	Nursing Care	0	23,365		10.00
11.00	Nursing Care-Continuous Home Care	0	0		11.00
12.00	Physical Therapy	0	0		12.00
13.00	Occupational Therapy	0	0		13.00
14.00	Speech/ Language Pathology	0	0		14.00
15.00	Medical Social Services	0	29,987		15.00
16.00	Spiritual Counseling	0	7,135		16.00
17.00	Dietary Counseling	0	0		17.00
18.00	Counseling - Other	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		20.00
21.00	Other	0	0		21.00
	OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0		22.00
23.00	Analgesics	0	0		23.00
24.00	Sedatives / Hypnotics	0	0		24.00
25.00	Other - Specify	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0		26.00
27.00	Patient Transportation	0	0		27.00
28.00	Imaging Services	0	0		28.00
29.00	Labs and Diagnostics	0	0		29.00
30.00	Medical Supplies	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		31.00
32.00	Radiation Therapy	0	0		32.00
33.00	Chemotherapy	0	0		33.00
34.00	Other	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0		35.00
36.00	Volunteer Program Costs	0	0		36.00
37.00	Fundraising	0	0		37.00
38.00	Other Program Costs	0	0		38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		33,033		39.00
40.00	Unit Cost Multiplier		0.254401		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151315 Hospice CCN: 151561

Period: From 10/01/2014 To 09/30/2015

Worksheet K-5 Part I Date/Time Prepared: 9/6/2016 3:17 pm

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
1.00	Administrative and General		0	6,418	37,585	44,003	1.00
2.00	Inpatient - General Care	87,004	0	0	0	87,004	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	29,309	0	0	0	29,309	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	37,616	0	0	0	37,616	10.00
11.00	Spiritual Counseling	8,950	0	0	0	8,950	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	162,879	0	6,418	37,585	206,882	34.00
35.00	Unit Cost Multiplier (see instructions)					0	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151315 Hospice CCN: 151561

Period: From 10/01/2014 To 09/30/2015

Worksheet K-5 Part I Date/Time Prepared: 9/6/2016 3:17 pm

Hospice I

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	11,682	12,094	0	0	0	1.00
2.00	Inpatient - General Care	23,099	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	7,781	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	9,986	0	0	0	0	10.00
11.00	Spiritual Counseling	2,376	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	54,924	12,094	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151315
Hospice CCN: 151561

Period:
From 10/01/2014
To 09/30/2015

Worksheet K-5
Part I
Date/Time Prepared:
9/6/2016 3:17 pm

Hospice I

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	11,114	0	395	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	11,114	0	395	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151315 Hospice CCN: 151561

Period: From 10/01/2014 To 09/30/2015

Worksheet K-5 Part I Date/Time Prepared: 9/6/2016 3:17 pm

Hospice I

	Cost Center Description	Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	79,288					1.00
2.00	Inpatient - General Care	110,103	0	110,103	42,353	152,456	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	37,090	0	37,090	14,267	51,357	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	47,602	0	47,602	18,311	65,913	10.00
11.00	Spiritual Counseling	11,326	0	11,326	4,357	15,683	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	285,409	0	285,409		285,409	34.00
35.00	Unit Cost Multiplier (see instructions)				0.384667		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151315
Hospice CCN: 151561

Period:
From 10/01/2014
To 09/30/2015

Worksheet K-5
Part II
Date/Time Prepared:
9/6/2016 3:17 pm

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
1.00	Administrative and General	0	301	125,040	0	44,003	1.00
2.00	Inpatient - General Care	0	0	0	0	87,004	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	29,309	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	37,616	10.00
11.00	Spiritual Counseling	0	0	0	0	8,950	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	301	125,040		206,882	34.00
35.00	Total cost to be allocated	0	6,418	37,585		54,924	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	21.322259	0.300584		0.265485	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151315
Hospice CCN: 151561

Period:
From 10/01/2014
To 09/30/2015

Worksheet K-5
Part II
Date/Time Prepared:
9/6/2016 3:17 pm

Hospice I

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	301	0	0	0	245	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	301	0	0	0	245	34.00
35.00	Total cost to be allocated	12,094	0	0	0	11,114	35.00
36.00	Unit Cost Multiplier (see instructions)	40.179402	0.000000	0.000000	0.000000	45.363265	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151315
Hospice CCN: 151561

Period:
From 10/01/2014
To 09/30/2015

Worksheet K-5
Part II
Date/Time Prepared:
9/6/2016 3:17 pm

Hospice I

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
		13.00	14.00	15.00	16.00		
1.00	Administrative and General	0	2,322	0	0		1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	0	0	0		4.00
5.00	Nursing Care	0	0	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00	Physical Therapy	0	0	0	0		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0	0		11.00
12.00	Dietary Counseling	0	0	0	0		12.00
13.00	Counseling - Other	0	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00	Other	0	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00	Analgesics	0	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0	0		19.00
20.00	Other - Specify	0	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00	Patient Transportation	0	0	0	0		22.00
23.00	Imaging Services	0	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0	0		24.00
25.00	Medical Supplies	0	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00	Radiation Therapy	0	0	0	0		27.00
28.00	Chemotherapy	0	0	0	0		28.00
29.00	Other	0	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0	0		31.00
32.00	Fundraising	0	0	0	0		32.00
33.00	Other Program Costs	0	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	2,322	0	0		34.00
35.00	Total cost to be allocated	0	395	0	0		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.170112	0.000000	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 151315 Hospice CCN: 151561

Period: From 10/01/2014 To 09/30/2015

Worksheet K-5 Part III Date/Time Prepared: 9/6/2016 3:17 pm

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Hospice I Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.624727	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00				2.00
3.00	SPEECH PATHOLOGY	68.00				3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.437606	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.302420	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.668498	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	CHEMICAL DEPENDENCY	76.00	3.599082	0	0	10.00
10.01	ONCOLOGY	76.01	0.450556	0	0	10.01
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 151315 Hospice CCN: 151561

Period: From 10/01/2014 To 09/30/2015

Worksheet K-6

Date/Time Prepared: 9/6/2016 3:17 pm

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				285,409	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				3,196	2.00
3.00	Average cost per diem (line 1 divided by line 2)				89.30	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	3,022				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	269,865				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		14			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		1,250			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	404				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	36,077				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			160		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			14,288		13.00