This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0030	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 2/15/2017 2:12 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/15/2017 Time: 2:12 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [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 HENRY COUNTY MEMORIAL HOSPITAL (15-0030) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 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.

Encryption Information

ECR: Date: 2/15/2017 Time: 2:12 pm
XbOw.xiAUEHwI2cW4k1Y8DHaNt92kO
NIhaoONdLaYqrLi1e7jXFcvjozjgIk
vIzn1TXQ2xOGW44L

PI: Date: 2/15/2017 Time: 2:12 pm
DwgMVY6Ib3E5h:haTheJ6LO1dMT9QO
lEzcZOQ2lNdPMhuM5opRX:Un7eSqlX
LM6gOEhYYfOcqJNE

(Signed) Paul Ingram
Officer or Administrator of Provider(s)

President / CEO
Title

2-16-2017
Date

		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	1,561	15,117	37,904	-37,593	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing bed - SNF	0	0	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	1,561	15,117	37,904	-37,593	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/15/2017 2:11 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 NORTH 16TH STREET	PO Box:			1.00
2.00	City: NEW CASTLE	State: IN	Zip Code: 47392-	County: HENRY	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	HENRY COUNTY MEMORIAL HOSPITAL	150030	99915	1	07/01/1996	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HCMH HOME CARE	157430	99915		06/14/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HOSP-BASED HOSPICE	151564	99915		08/31/1998				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)	01/01/2015	12/31/2015	20.00
21.00	Type of Control (see instructions)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	204	678	0	0	830	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: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/15/2017 2:11 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.	1		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.	1		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.	1		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.	01/01/2015	12/31/2015	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)	Y	Y	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.				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: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/15/2017 2:11 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: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/15/2017 2:11 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)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 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	N	109.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1	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: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/15/2017 2:11 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)	0.25	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0030	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 2/15/2017 2:11 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)	01/01/2015	12/31/2015	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/15/2017 2:11 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y	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	04/06/2016	Y	04/06/2016	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 2/15/2017 2:11 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	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	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	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	Y	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		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: 15-0030	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 2/15/2017 2:11 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.	SENIOR 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: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/15/2017 2:11 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	38	13,870	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		38	13,870	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,650	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		48	17,520	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	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)		48				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: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/15/2017 2:11 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)	2,905	191	5,407			1.00
2.00	HMO and other (see instructions)	840	1,287				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,905	191	5,407			7.00
8.00	INTENSIVE CARE UNIT	988	0	1,742			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	812			13.00
14.00	Total (see instructions)	3,893	191	7,961	0.00	439.43	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	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	5,450	54	8,645	0.00	12.38	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	5,719	120	6,217	0.00	5.59	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	457.40	27.00
28.00	Observation Bed Days		41	1,664			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	234	350			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: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/15/2017 2:11 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	1,040	38	2,174	1.00
2.00	HMO and other (see instructions)			201	343		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	1,040	38	2,174	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0		0	0	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

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 2/15/2017 2:11 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	31,189,220	0	31,189,220	1,106,010.00	28.20	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		6,410,387	459,414	6,869,801	214,524.00	32.02	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		838,560	0	838,560	20,994.00	39.94	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		177,004	0	177,004	1,532.00	115.54	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,190,357	0	8,190,357			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,351,993	0	1,351,993			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related							25.50
25.51	Related orgainzation wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	950,022	-705,876	244,146	8,119.00	30.07	26.00
27.00	Administrative & General	5.00	5,560,805	136,853	5,697,658	175,912.00	32.39	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 2/15/2017 2:11 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		725,484	0	725,484	6,100.00	118.93	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	986,040	22,519	1,008,559	42,106.00	23.95	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	465,052	-31,640	433,412	39,033.00	11.10	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	685,168	-462,176	222,992	14,095.00	15.82	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	278,726	278,726	18,342.00	15.20	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,559,009	41,786	1,600,795	38,419.00	41.67	38.00
39.00	Central Services and Supply	14.00	417,028	11,387	428,415	16,169.00	26.50	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	594,488	11,979	606,467	28,420.00	21.34	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part III Date/Time Prepared: 2/15/2017 2:11 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		31,914,704	0	31,914,704	1,112,110.00	28.70	1.00
2.00	Excluded area salaries (see instructions)		6,410,387	459,414	6,869,801	214,524.00	32.02	2.00
3.00	Subtotal salaries (line 1 minus line 2)		25,504,317	-459,414	25,044,903	897,586.00	27.90	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,015,564	0	1,015,564	22,526.00	45.08	4.00
5.00	Subtotal wage-related costs (see inst.)		8,190,357	0	8,190,357	0.00	32.70	5.00
6.00	Total (sum of lines 3 thru 5)		34,710,238	-459,414	34,250,824	920,112.00	37.22	6.00
7.00	Total overhead cost (see instructions)		11,943,096	-696,442	11,246,654	386,715.00	29.08	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part IV Date/Time Prepared: 2/15/2017 2:11 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	995,980	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	787	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	4,614,022	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)		8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	129,766	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	160,907	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	223,829	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	159,059	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,774,974	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	18,357	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,077,681	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER	451,713	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part V Date/Time Prepared: 2/15/2017 2:11 pm

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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-0030 | Component CCN: 15-7430 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-4 | Date/Time Prepared: 2/15/2017 2:11 pm

Home Health Agency I | PPS

					1.00		
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	297.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			34620			20.00
20.01				50031			20.01
20.02				99915			20.02
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	2,149	163	50	33	2,395	21.00
22.00	Skilled Nursing Visit Charges	569,229	43,358	13,300	8,778	634,665	22.00
23.00	Physical Therapy Visits	1,861	39	12	22	1,934	23.00
24.00	Physical Therapy Visit Charges	493,999	10,374	3,192	5,852	513,417	24.00
25.00	Occupational Therapy Visits	509	24	0	28	561	25.00
26.00	Occupational Therapy Visit Charges	131,714	6,240	0	7,280	145,234	26.00
27.00	Speech Pathology Visits	40	0	0	1	41	27.00
28.00	Speech Pathology Visit Charges	10,264	0	0	260	10,524	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	454	53	0	12	519	31.00
32.00	Home Health Aide Visit Charges	56,432	6,625	0	1,500	64,557	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,013	279	62	96	5,450	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,261,638	66,597	16,492	23,670	1,368,397	35.00
36.00	Total Number of Episodes (standard/non outlier)	312		20	4	336	36.00
37.00	Total Number of Outlier Episodes		6		1	7	37.00
38.00	Total Non-Routine Medical Supply Charges	117	18	0	0	135	38.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-0030
Hospice CCN: 15-1564

Period: From 01/01/2015 To 12/31/2015

Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 2/15/2017 2:11 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 FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Hospice Routine Home Care	5,673	115	3,100	0	376	6,164	2.00
3.00	Hospice Inpatient Respite Care	5	0	0	0	0	5	3.00
4.00	Hospice General Inpatient Care	41	5	0	0	2	48	4.00
5.00	Total Hospice Days	5,719	120	3,100	0	378	6,217	5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care	107	3	62	0	5	115	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)	53.45	40.00	50.00	0.00	75.60	54.06	8.00
9.00	Unduplicated census count	89	2	53	0	5	96	9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care					10.00
11.00	Hospice Routine Home Care					11.00
12.00	Hospice Inpatient Respite Care					12.00
13.00	Hospice General Inpatient Care					13.00
14.00	Total Hospice Days					14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care					15.00
16.00	Hospice General Inpatient Care					16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-10 | Date/Time Prepared: 2/15/2017 2:11 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)	0.310307	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,503,186	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	2,073,722	5.00
6.00	Medicaid charges	14,907,597	6.00
7.00	Medicaid cost (line 1 times line 6)	4,625,932	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	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 , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	1,949,121	0	1,949,121	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	604,826	0	604,826	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)	604,826	0	604,826	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)	3,531,504	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	233,558	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	3,297,946	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,023,376	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,628,202	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,628,202	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 2/15/2017 2:11 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	NEW CAP REL COSTS-BLDG & FIXT		4,811,672	4,811,672	-34,728	4,776,944	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	743,180	743,180	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	950,022	7,247,240	8,197,262	-587,376	7,609,886	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,560,805	8,455,191	14,015,996	136,853	14,152,849	5.00
7.00	00700	OPERATION OF PLANT	986,040	1,669,145	2,655,185	22,474	2,677,659	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	313,933	313,933	0	313,933	8.00
9.00	00900	HOUSEKEEPING	465,052	272,460	737,512	-53,829	683,683	9.00
10.00	01000	DIETARY	685,168	539,823	1,224,991	-835,783	389,208	10.00
11.00	01100	CAFETERIA	0	0	0	498,326	498,326	11.00
13.00	01300	NURSING ADMINISTRATION	1,559,009	305,802	1,864,811	41,786	1,906,597	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	417,028	389,073	806,101	11,387	817,488	14.00
15.00	01500	PHARMACY	0	3,743,198	3,743,198	-138,821	3,604,377	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	594,488	252,698	847,186	11,979	859,165	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,143,794	396,260	3,540,054	-617,525	2,922,529	30.00
31.00	03100	INTENSIVE CARE UNIT	1,128,217	109,353	1,237,570	17,295	1,254,865	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	568,462	568,462	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,915,036	1,047,465	2,962,501	-258,553	2,703,948	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	102,205	102,205	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,436,809	759,577	2,196,386	-249,545	1,946,841	54.00
57.00	05700	CT SCAN	144,627	717,171	861,798	3,006	864,804	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	83,264	484,457	567,721	1,960	569,681	58.00
59.00	05900	CARDIAC CATHETERIZATION	38,300	801,040	839,340	0	839,340	59.00
60.00	06000	LABORATORY	1,610,794	1,939,271	3,550,065	-84,317	3,465,748	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	324,924	104,577	429,501	2,627	432,128	65.00
66.00	06600	PHYSICAL THERAPY	1,215,249	986,098	2,201,347	22,366	2,223,713	66.00
68.00	06800	SPEECH PATHOLOGY	50,345	3,796	54,141	1,194	55,335	68.00
69.00	06900	ELECTROCARDIOLOGY	180,485	89,847	270,332	0	270,332	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,272,721	5,272,721	-4,209,494	1,063,227	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	4,209,494	4,209,494	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	124,945	21,702	146,647	1,980	148,627	76.00
		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
91.00	09100	EMERGENCY	2,164,432	807,871	2,972,303	33,221	3,005,524	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	931,495	240,021	1,171,516	14,854	1,186,370	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	329,817	491,059	820,876	-25,775	795,101	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,040,145	42,272,521	68,312,666	-651,097	67,661,569	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	576,157	679,546	1,255,703	141,352	1,397,055	192.00
194.00	07950	MCH	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	0	34,728	34,728	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	22,861	22,861	0	22,861	194.05
194.06	07956	RHC- FOREST RIDGE	4,098,069	1,984,795	6,082,864	58,803	6,141,667	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	0	0	409,543	409,543	194.09
194.10	07960	CAMBRIDGE CITY	79,008	149,761	228,769	357	229,126	194.10
194.11	07961	WELL BEING	395,841	222,600	618,441	6,314	624,755	194.11
200.00		TOTAL (SUM OF LINES 118-199)	31,189,220	45,332,084	76,521,304	0	76,521,304	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 2/15/2017 2:11 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-72,168	4,704,776		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	743,180		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,147,006	8,756,892		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,512,033	11,640,816		5.00
7.00	00700	OPERATION OF PLANT	0	2,677,659		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	313,933		8.00
9.00	00900	HOUSEKEEPING	0	683,683		9.00
10.00	01000	DIETARY	-100,868	288,340		10.00
11.00	01100	CAFETERIA	-336,820	161,506		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,906,597		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	817,488		14.00
15.00	01500	PHARMACY	-806,174	2,798,203		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-21,815	837,350		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-3,160	2,919,369		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,254,865		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	568,462		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,703,948		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	102,205		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-14,553	1,932,288		54.00
57.00	05700	CT SCAN	-483,039	381,765		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-322,211	247,470		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	839,340		59.00
60.00	06000	LABORATORY	-25,965	3,439,783		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	-11,355	420,773		65.00
66.00	06600	PHYSICAL THERAPY	-742,513	1,481,200		66.00
68.00	06800	SPEECH PATHOLOGY	0	55,335		68.00
69.00	06900	ELECTROCARDIOLOGY	0	270,332		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,063,227		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,209,494		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	CARDIAC REHAB	-106	148,521		76.00
		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
91.00	09100	EMERGENCY	-14,357	2,991,167		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	3,047	1,189,417		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	4,202	799,303		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,312,882	63,348,687		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-110	1,396,945		192.00
194.00	07950	MCH	0	0		194.00
194.01	07951	RENTAL	0	34,728		194.01
194.02	07952	CMHS	0	0		194.02
194.03	07953	MCH	0	0		194.03
194.04	07954	WIC	0	0		194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	22,861		194.05
194.06	07956	RHC- FOREST RIDGE	0	6,141,667		194.06
194.07	07957	PHILLIPS HALL	0	0		194.07
194.08	07958	OB DRS	0	0		194.08
194.09	07959	THE WATERS	0	409,543		194.09
194.10	07960	CAMBRIDGE CITY	0	229,126		194.10
194.11	07961	WELL BEING	0	624,755		194.11
200.00		TOTAL (SUM OF LINES 118-199)	-4,312,992	72,208,312		200.00

RECLASSIFICATIONS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 2/15/2017 2:11 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - OB/NURSERY/L&D				
1.00	NURSERY	43.00	503,036	65,426	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	90,442	11,763	2.00
	0		593,478	77,189	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	278,726	219,600	1.00
	0		278,726	219,600	
	C - WATERS EXCLUSIONS				
1.00	THE WATERS	194.09	233,347	176,196	1.00
2.00		0.00	0	0	2.00
	0		233,347	176,196	
	D - DEPRECIATION POB				
1.00	RENTAL	194.01	0	34,728	1.00
	0		0	34,728	
	E - EQUIPMENT RENTAL				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	743,180	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	0		0	743,180	
	F - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	4,209,494	1.00
	0		0	4,209,494	
	G - BONUS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	6,264	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	136,853	0	2.00
3.00	OPERATION OF PLANT	7.00	22,519	0	3.00
4.00	HOUSEKEEPING	9.00	6,234	0	4.00
5.00	DIETARY	10.00	12,023	0	5.00
6.00	NURSING ADMINISTRATION	13.00	41,786	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	11,387	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	11,979	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	53,142	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	17,295	0	10.00
11.00	OPERATING ROOM	50.00	33,923	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	28,218	0	12.00
13.00	CT SCAN	57.00	3,006	0	13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	1,960	0	14.00
15.00	LABORATORY	60.00	34,183	0	15.00
16.00	RESPIRATORY THERAPY	65.00	6,025	0	16.00
17.00	PHYSICAL THERAPY	66.00	22,881	0	17.00
18.00	SPEECH PATHOLOGY	68.00	1,194	0	18.00
19.00	CARDIAC REHAB	76.00	1,980	0	19.00
20.00	EMERGENCY	91.00	33,221	0	20.00
21.00	HOME HEALTH AGENCY	101.00	15,170	0	21.00
22.00	HOSPICE	116.00	3,912	0	22.00
23.00	PHYSICIANS' PRIVATE OFFICES	192.00	141,511	0	23.00
24.00	RHC- FOREST RIDGE	194.06	58,803	0	24.00
25.00	CAMBRIDGE CITY	194.10	357	0	25.00
26.00	WELL BEING	194.11	6,314	0	26.00
	0		712,140	0	
	H - PHYSICIAN EMPLOYEE BENEFIT				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	118,500	1.00
	TOTALS		0	118,500	
500.00	Grand Total: Increases		1,817,691	5,578,887	500.00

RECLASSIFICATIONS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 2/15/2017 2:11 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - OB/NURSERY/L&D						
1.00	ADULTS & PEDIATRICS	30.00	593,478	77,189	0		1.00
2.00		0.00	0	0	0		2.00
	0		593,478	77,189			
	B - CAFETERIA						
1.00	DIETARY	10.00	278,726	219,600	0		1.00
	0		278,726	219,600			
	C - WATERS EXCLUSIONS						
1.00	HOUSEKEEPING	9.00	37,874	22,189	0		1.00
2.00	DIETARY	10.00	195,473	154,007	0		2.00
	0		233,347	176,196			
	D - DEPRECIATION POB						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	34,728	9		1.00
	0		0	34,728			
	E - EQUIPMENT RENTAL						
1.00	OPERATION OF PLANT	7.00	0	45	9		1.00
2.00	PHARMACY	15.00	0	138,821	0		2.00
3.00	OPERATING ROOM	50.00	0	292,476	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	277,763	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	3,398	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	515	0		6.00
7.00	HOME HEALTH AGENCY	101.00	0	316	0		7.00
8.00	HOSPICE	116.00	0	29,687	0		8.00
9.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	159	0		9.00
	0		0	743,180			
	F - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,209,494	0		1.00
	0		0	4,209,494			
	G - BONUS RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	712,140	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
	0		712,140	0			
	H - PHYSICIAN EMPLOYEE BENEFIT						
1.00	LABORATORY	60.00	0	118,500	0		1.00
	TOTALS		0	118,500			
500.00	Grand Total: Decreases		1,817,691	5,578,887			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I Date/Time Prepared: 2/15/2017 2:11 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	46,000	0	0	0	0	1.00
2.00	Land Improvements	1,621,597	0	0	0	0	2.00
3.00	Buildings and Fixtures	36,392,851	4,684,124	0	4,684,124	0	3.00
4.00	Building Improvements	205,296	0	0	0	0	4.00
5.00	Fixed Equipment	15,735,005	54,316	0	54,316	0	5.00
6.00	Movable Equipment	31,891,147	3,098,823	0	3,098,823	539,936	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	85,891,896	7,837,263	0	7,837,263	539,936	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	85,891,896	7,837,263	0	7,837,263	539,936	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	46,000	0	1.00
2.00	Land Improvements	1,621,597	0	2.00
3.00	Buildings and Fixtures	41,076,975	0	3.00
4.00	Building Improvements	205,296	0	4.00
5.00	Fixed Equipment	15,789,321	0	5.00
6.00	Movable Equipment	34,450,034	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	93,189,223	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	93,189,223	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 2/15/2017 2:11 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	NEW CAP REL COSTS-BLDG & FIXT	4,553,139	0	258,533	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,553,139	0	258,533	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	NEW CAP REL COSTS-BLDG & FIXT	0	4,811,672	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	4,811,672	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 2/15/2017 2:11 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	NEW CAP REL COSTS-BLDG & FIXT	42,273,949	0	42,273,949	0.455938	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	50,444,651	0	50,444,651	0.544062	0	2.00
3.00	Total (sum of lines 1-2)	92,718,600	0	92,718,600	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	4,518,411	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	743,180	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,261,591	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	NEW CAP REL COSTS-BLDG & FIXT	186,365	0	0	0	4,704,776	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	743,180	2.00
3.00	Total (sum of lines 1-2)	186,365	0	0	0	5,447,956	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 2/15/2017 2:11 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-72,168	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-13,284	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-20,123	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,917			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	-1,551,968			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-336,820	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-21,815	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		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW 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	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 2/15/2017 2:11 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	
33.00	OTHER OP REV - HUMAN RESOURSEC - MIS	B	-358	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
34.00	OTHER OP REV	B	-17,153	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	OTHER OP REV - COPIES RECEIPTS	B	-17	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	OTHER OP REV - PHY REAPP FEES	B	-33,600	ADMINISTRATIVE & GENERAL	5.00	0	36.00
36.01	OTHER OP REV - DIETARY - OUTSIDE SAL	B	-75,554	DIETARY	10.00	0	36.01
38.00	OTHER OP REV - DIETARY TRANSFERS	B	-25,314	DIETARY	10.00	0	38.00
38.01	OTHER OP REV - PHARMACY	B	-806,174	PHARMACY	15.00	0	38.01
40.00	OTHER OP REV - PCU - HLTH PROG REC	B	-646	ADULTS & PEDIATRICS	30.00	0	40.00
40.01	OTHER OP REV - WOMEN & CH UNIT- HLTH	B	-28	ADULTS & PEDIATRICS	30.00	0	40.01
40.02	OTHER OP REV - LAB-LAB DRUG SCREEN	B	-24,092	LABORATORY	60.00	0	40.02
40.03	OTHER OP REV-LABORATORY	B	3,044	LABORATORY	60.00	0	40.03
41.00	OTHER OP REV - ATH TRAINING - HLTH P	B	-72,396	PHYSICAL THERAPY	66.00	0	41.00
42.00	OTHER OP REV - ATH TRAINING - OUTSID	B	-7,645	PHYSICAL THERAPY	66.00	0	42.00
43.00	OTHER OP REV - AQUATICS - HLTH PROG	B	-20,952	PHYSICAL THERAPY	66.00	0	43.00
44.00	OTHER OP REV - PHYSICAL THER	B	-177	PHYSICAL THERAPY	66.00	0	44.00
44.01	OTHER OP REV - PHYSICAL THER - HLTH	B	-630	PHYSICAL THERAPY	66.00	0	44.01
45.00	OTHER OP REV - PHYSICAL THER - EE	B	-9,430	PHYSICAL THERAPY	66.00	0	45.00
45.01	OTHER OP REV - PHYSICAL THER - FIT F	B	-58,390	PHYSICAL THERAPY	66.00	0	45.01
45.02	PUBLIC RELATIONS	A	-650	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.02
45.03	PUBLIC RELATIONS	A	-141,497	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	PUBLIC RELATIONS	A	-2,486	ADULTS & PEDIATRICS	30.00	0	45.04
45.05	PUBLIC RELATIONS	A	-1,117	RADIOLOGY-DIAGNOSTIC	54.00	0	45.05
45.06	PUBLIC RELATIONS	A	-182	RESPIRATORY THERAPY	65.00	0	45.06
45.07	PUBLIC RELATIONS	A	-590	PHYSICAL THERAPY	66.00	0	45.07
45.08	PUBLIC RELATIONS	A	-106	CARDIAC REHAB	76.00	0	45.08
45.09	PUBLIC RELATIONS	A	-14,357	EMERGENCY	91.00	0	45.09
45.10	PUBLIC RELATIONS	A	-1,622	HOME HEALTH AGENCY	101.00	0	45.10
45.11	PUBLIC RELATIONS	A	-463	HOSPICE	116.00	0	45.11
45.12	PUBLIC RELATIONS	A	-110	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.12
45.13	AHA & IHA DUES	A	-5,853	ADMINISTRATIVE & GENERAL	5.00	0	45.13
45.14	BENEFIT EXPENSE	A	1,148,014	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.14
45.15	HOSPITALIST EXPENSE	A	-124,000	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16	HAF EXPENSE	A	-1,997,366	ADMINISTRATIVE & GENERAL	5.00	0	45.16
45.17			0		0.00	0	45.17
45.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.18
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,312,992				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: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-1 | Date/Time Prepared: 2/15/2017 2:11 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	54.00	RADIOLOGY-DIAGNOSTIC	XRAY	5,528	18,964	1.00
2.00	57.00	CT SCAN	CT SCAN	175,711	658,750	2.00
3.00	58.00	MAGNETIC RESONANCE IMAGING (	MRI	127,789	450,000	3.00
4.00	66.00	PHYSICAL THERAPY	PHYSICAL THERAPY	214,025	786,328	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	0	159,140	4.01
4.02	65.00	RESPIRATORY THERAPY	RESPIRATORY THERAPY	28,764	39,937	4.02
4.03	101.00	HOME HEALTH AGENCY	HOME HEALTH AGENCY	11,189	6,520	4.03
4.04	116.00	HOSPICE	HOSPICE	11,185	6,520	4.04
5.00	0		0	574,191	2,126,159	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	G	HENRY COUNTY HO	100.00	HOSPITAL FOUNDATION	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:	MISC				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: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-1 | Date/Time Prepared: 2/15/2017 2:11 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	-13,436	0		1.00
2.00	-483,039	0		2.00
3.00	-322,211	0		3.00
4.00	-572,303	0		4.00
4.01	-159,140	0		4.01
4.02	-11,173	0		4.02
4.03	4,669	0		4.03
4.04	4,665	0		4.04
5.00	-1,551,968			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	MISC		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: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 2/15/2017 2:11 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	80,004	0	80,004	260,300	600	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		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			80,004	0	80,004		600	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	75,087	3,754	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		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			75,087	3,754	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	75,087	4,917	4,917		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		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	75,087	4,917	4,917		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 2/15/2017 2:11 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	4,704,776	4,704,776				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	743,180		743,180			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,756,892	24,729	3,649	8,785,270		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,640,816	526,900	77,755	1,617,555	13,863,026	5.00
7.00	00700	OPERATION OF PLANT	2,677,659	1,250,958	184,605	286,329	4,399,551	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	313,933	62,158	9,173	0	385,264	8.00
9.00	00900	HOUSEKEEPING	683,683	37,720	5,566	123,045	850,014	9.00
10.00	01000	DIETARY	288,340	131,148	19,354	63,307	502,149	10.00
11.00	01100	CAFETERIA	161,506	35,830	5,288	79,130	281,754	11.00
13.00	01300	NURSING ADMINISTRATION	1,906,597	66,664	9,838	454,464	2,437,563	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	817,488	129,967	19,179	121,627	1,088,261	14.00
15.00	01500	PHARMACY	2,798,203	28,381	4,188	0	2,830,772	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	837,350	96,317	14,214	172,175	1,120,056	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,919,369	534,822	78,924	739,119	4,272,234	30.00
31.00	03100	INTENSIVE CARE UNIT	1,254,865	210,785	31,106	325,210	1,821,966	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	568,462	55,744	8,226	142,811	775,243	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,703,948	295,692	43,635	553,308	3,596,583	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	102,205	28,326	4,180	25,676	160,387	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,932,288	205,716	30,358	415,920	2,584,282	54.00
57.00	05700	CT SCAN	381,765	7,958	1,174	41,913	432,810	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	247,470	9,721	1,434	24,195	282,820	58.00
59.00	05900	CARDIAC CATHETERIZATION	839,340	88,413	13,047	10,873	951,673	59.00
60.00	06000	LABORATORY	3,439,783	150,099	22,150	467,007	4,079,039	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	420,773	31,542	4,655	93,956	550,926	65.00
66.00	06600	PHYSICAL THERAPY	1,481,200	22,657	3,344	351,504	1,858,705	66.00
68.00	06800	SPEECH PATHOLOGY	55,335	3,507	517	14,632	73,991	68.00
69.00	06900	ELECTROCARDIOLOGY	270,332	0	0	51,240	321,572	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,063,227	0	0	0	1,063,227	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,209,494	0	0	0	4,209,494	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	148,521	12,919	1,906	36,034	199,380	76.00
		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
91.00	09100	EMERGENCY	2,991,167	192,016	28,336	623,911	3,835,430	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,189,417	0	0	268,757	1,458,174	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	799,303	0	0	94,745	894,048	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	63,348,687	4,240,689	625,801	7,198,443	61,180,394	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,333	0	0	18,333	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,396,945	0	0	203,745	1,600,690	192.00
194.00	07950	MCH	0	0	0	0	0	194.00
194.01	07951	RENTAL	34,728	0	51,599	0	86,327	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	22,861	0	0	0	22,861	194.05
194.06	07956	RHC- FOREST RIDGE	6,141,667	0	0	1,180,132	7,321,799	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	409,543	445,754	65,780	66,247	987,324	194.09
194.10	07960	CAMBRIDGE CITY	229,126	0	0	22,532	251,658	194.10
194.11	07961	WELL BEING	624,755	0	0	114,171	738,926	194.11
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)	72,208,312	4,704,776	743,180	8,785,270	72,208,312	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 2/15/2017 2:11 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,863,026					5.00
7.00	00700	OPERATION OF PLANT	1,045,347	5,444,898				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	91,540	138,507	615,311			8.00
9.00	00900	HOUSEKEEPING	201,966	84,052	26,048	1,162,080		9.00
10.00	01000	DIETARY	119,312	292,238	6,996	22,688	943,383	10.00
11.00	01100	CAFETERIA	66,946	79,841	0	7,779	0	11.00
13.00	01300	NURSING ADMINISTRATION	579,172	148,548	0	13,397	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	258,574	289,606	0	13,397	0	14.00
15.00	01500	PHARMACY	672,600	63,241	0	6,698	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	266,129	214,623	0	9,508	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,015,096	1,191,743	123,963	286,523	724,237	30.00
31.00	03100	INTENSIVE CARE UNIT	432,905	469,694	27,936	44,513	219,146	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	184,200	124,215	10,362	3,889	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	854,559	658,891	110,367	101,558	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	38,108	63,120	1,862	8,211	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	614,033	458,398	44,669	66,769	0	54.00
57.00	05700	CT SCAN	102,837	17,733	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	67,199	21,661	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	226,120	197,011	1,457	12,533	0	59.00
60.00	06000	LABORATORY	969,192	334,466	776	30,035	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	130,902	70,286	0	25,065	0	65.00
66.00	06600	PHYSICAL THERAPY	441,634	50,488	13,519	137,211	0	66.00
68.00	06800	SPEECH PATHOLOGY	17,580	7,814	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	76,406	0	0	4,322	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	252,626	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,000,188	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	47,373	0	0	0	0	76.00
		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
91.00	09100	EMERGENCY	911,310	427,870	109,963	74,764	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	346,467	0	0	11,884	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	212,428	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,242,749	5,404,046	477,918	880,744	943,383	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,356	40,852	0	2,809	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	380,329	0	305	0	0	192.00
194.00	07950	MCH	0	0	0	0	0	194.00
194.01	07951	RENTAL	20,512	0	0	256,271	0	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	5,432	0	12,998	0	0	194.05
194.06	07956	RHC- FOREST RIDGE	1,739,691	0	3,816	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	4,985	22,256	0	194.07
194.08	07958	OB DRS	0	0	8,237	0	0	194.08
194.09	07959	THE WATERS	234,591	0	107,052	0	0	194.09
194.10	07960	CAMBRIDGE CITY	59,795	0	0	0	0	194.10
194.11	07961	WELL BEING	175,571	0	0	0	0	194.11
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)	13,863,026	5,444,898	615,311	1,162,080	943,383	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 2/15/2017 2:11 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	436,320					11.00
13.00	01300	NURSING ADMINISTRATION	28,198	3,206,878				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,863	0	1,661,701			14.00
15.00	01500	PHARMACY	0	0	2,741	3,576,052		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,855	0	3,051	0	1,634,222	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	72,902	1,024,135	29,889	0	227,825	30.00
31.00	03100	INTENSIVE CARE UNIT	27,267	383,058	6,744	0	94,531	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	12,015	168,794	0	0	51,686	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	56,412	792,497	87,322	0	238,027	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,153	30,241	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,572	0	42,327	0	184,981	54.00
57.00	05700	CT SCAN	3,481	0	10,895	0	57,806	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,412	0	3,863	0	31,283	58.00
59.00	05900	CARDIAC CATHETERIZATION	809	0	0	0	8,841	59.00
60.00	06000	LABORATORY	53,924	0	208,440	0	235,986	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	8,473	0	3,196	0	18,362	65.00
66.00	06600	PHYSICAL THERAPY	33,466	0	8,160	0	20,402	66.00
68.00	06800	SPEECH PATHOLOGY	931	0	20	0	680	68.00
69.00	06900	ELECTROCARDIOLOGY	4,061	0	4,776	0	21,082	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	243,873	0	78,209	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	965,534	0	71,408	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,576,052	0	73.00
76.00	03950	CARDIAC REHAB	3,908	54,906	1,814	0	2,040	76.00
		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
91.00	09100	EMERGENCY	53,618	753,247	31,804	0	269,311	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	4,572	0	10,881	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	2,680	0	10,881	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	436,320	3,206,878	1,661,701	3,576,052	1,634,222	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MCH	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	0	0	0	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.05
194.06	07956	RHC- FOREST RIDGE	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	0	0	0	0	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	0	0	0	0	0	194.11
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)	436,320	3,206,878	1,661,701	3,576,052	1,634,222	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 2/15/2017 2:11 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	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW 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	8,968,547	0	8,968,547		30.00
31.00	03100	INTENSIVE CARE UNIT	3,527,760	0	3,527,760		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	1,330,404	0	1,330,404		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,496,216	0	6,496,216		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	304,082	0	304,082		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,035,031	0	4,035,031		54.00
57.00	05700	CT SCAN	625,562	0	625,562		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	409,238	0	409,238		58.00
59.00	05900	CARDIAC CATHETERIZATION	1,398,444	0	1,398,444		59.00
60.00	06000	LABORATORY	5,911,858	0	5,911,858		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	807,210	0	807,210		65.00
66.00	06600	PHYSICAL THERAPY	2,563,585	0	2,563,585		66.00
68.00	06800	SPEECH PATHOLOGY	101,016	0	101,016		68.00
69.00	06900	ELECTROCARDIOLOGY	432,219	0	432,219		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,637,935	0	1,637,935		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,246,624	0	6,246,624		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,576,052	0	3,576,052		73.00
76.00	03950	CARDIAC REHAB	309,421	0	309,421		76.00
		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
91.00	09100	EMERGENCY	6,467,317	0	6,467,317		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	1,831,978	0	1,831,978		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	1,120,037	0	1,120,037		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	58,100,536	0	58,100,536		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	66,350	0	66,350		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,981,324	0	1,981,324		192.00
194.00	07950	MCH	0	0	0		194.00
194.01	07951	RENTAL	363,110	0	363,110		194.01
194.02	07952	CMHS	0	0	0		194.02
194.03	07953	MCH	0	0	0		194.03
194.04	07954	WIC	0	0	0		194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	41,291	0	41,291		194.05
194.06	07956	RHC- FOREST RIDGE	9,065,306	0	9,065,306		194.06
194.07	07957	PHILLIPS HALL	27,241	0	27,241		194.07
194.08	07958	OB DRS	8,237	0	8,237		194.08
194.09	07959	THE WATERS	1,328,967	0	1,328,967		194.09
194.10	07960	CAMBRIDGE CITY	311,453	0	311,453		194.10
194.11	07961	WELL BEING	914,497	0	914,497		194.11
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)	72,208,312	0	72,208,312		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 2/15/2017 2:11 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	24,729	3,649	28,378	28,378	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	526,900	77,755	604,655	5,230	5.00
7.00	00700	OPERATION OF PLANT	0	1,250,958	184,605	1,435,563	925	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	62,158	9,173	71,331	0	8.00
9.00	00900	HOUSEKEEPING	0	37,720	5,566	43,286	397	9.00
10.00	01000	DIETARY	0	131,148	19,354	150,502	204	10.00
11.00	01100	CAFETERIA	0	35,830	5,288	41,118	256	11.00
13.00	01300	NURSING ADMINISTRATION	0	66,664	9,838	76,502	1,468	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	129,967	19,179	149,146	393	14.00
15.00	01500	PHARMACY	0	28,381	4,188	32,569	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	96,317	14,214	110,531	556	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	534,822	78,924	613,746	2,387	30.00
31.00	03100	INTENSIVE CARE UNIT	0	210,785	31,106	241,891	1,050	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	55,744	8,226	63,970	461	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	295,692	43,635	339,327	1,787	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	28,326	4,180	32,506	83	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	205,716	30,358	236,074	1,343	54.00
57.00	05700	CT SCAN	0	7,958	1,174	9,132	135	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	9,721	1,434	11,155	78	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	88,413	13,047	101,460	35	59.00
60.00	06000	LABORATORY	0	150,099	22,150	172,249	1,508	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	31,542	4,655	36,197	303	65.00
66.00	06600	PHYSICAL THERAPY	0	22,657	3,344	26,001	1,135	66.00
68.00	06800	SPEECH PATHOLOGY	0	3,507	517	4,024	47	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	166	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	12,919	1,906	14,825	116	76.00
		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
91.00	09100	EMERGENCY	0	192,016	28,336	220,352	2,015	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	0	0	868	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	0	0	306	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,240,689	625,801	4,866,490	23,252	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,333	0	18,333	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	658	192.00
194.00	07950	MCH	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	51,599	51,599	0	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.05
194.06	07956	RHC- FOREST RIDGE	0	0	0	0	3,812	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	445,754	65,780	511,534	214	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	73	194.10
194.11	07961	WELL BEING	0	0	0	0	369	194.11
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	4,704,776	743,180	5,447,956	28,378	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 2/15/2017 2:11 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	609,885					5.00
7.00	00700	OPERATION OF PLANT	45,989	1,482,477				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,027	37,711	113,069			8.00
9.00	00900	HOUSEKEEPING	8,885	22,885	4,787	80,240		9.00
10.00	01000	DIETARY	5,249	79,567	1,286	1,567	238,375	10.00
11.00	01100	CAFETERIA	2,945	21,738	0	537	0	11.00
13.00	01300	NURSING ADMINISTRATION	25,480	40,445	0	925	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,376	78,851	0	925	0	14.00
15.00	01500	PHARMACY	29,590	17,219	0	463	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,708	58,435	0	656	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	44,658	324,473	22,778	19,784	183,001	30.00
31.00	03100	INTENSIVE CARE UNIT	19,045	127,883	5,133	3,074	55,374	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	8,104	33,820	1,904	269	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,595	179,396	20,281	7,012	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,677	17,186	342	567	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,013	124,807	8,208	4,610	0	54.00
57.00	05700	CT SCAN	4,524	4,828	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,956	5,898	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,948	53,640	268	865	0	59.00
60.00	06000	LABORATORY	42,638	91,065	143	2,074	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	5,759	19,137	0	1,731	0	65.00
66.00	06600	PHYSICAL THERAPY	19,429	13,746	2,484	9,474	0	66.00
68.00	06800	SPEECH PATHOLOGY	773	2,128	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,361	0	0	298	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,114	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	44,002	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	2,084	0	0	0	0	76.00
		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
91.00	09100	EMERGENCY	40,092	116,496	20,207	5,162	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	15,242	0	0	821	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	9,345	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	494,608	1,471,354	87,821	60,814	238,375	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	192	11,123	0	194	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,732	0	56	0	0	192.00
194.00	07950	MCH	0	0	0	0	0	194.00
194.01	07951	RENTAL	902	0	0	17,695	0	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	239	0	2,389	0	0	194.05
194.06	07956	RHC- FOREST RIDGE	76,537	0	701	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	916	1,537	0	194.07
194.08	07958	OB DRS	0	0	1,514	0	0	194.08
194.09	07959	THE WATERS	10,320	0	19,672	0	0	194.09
194.10	07960	CAMBRIDGE CITY	2,631	0	0	0	0	194.10
194.11	07961	WELL BEING	7,724	0	0	0	0	194.11
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)	609,885	1,482,477	113,069	80,240	238,375	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 2/15/2017 2:11 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	66,594					11.00
13.00	01300	NURSING ADMINISTRATION	4,304	149,124				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,811	0	242,502			14.00
15.00	01500	PHARMACY	0	0	400	80,241		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,183	0	445	0	185,514	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,125	47,624	4,362	0	25,862	30.00
31.00	03100	INTENSIVE CARE UNIT	4,162	17,813	984	0	10,731	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	1,834	7,849	0	0	5,867	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,610	36,852	12,743	0	27,020	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	329	1,406	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,040	0	6,177	0	20,999	54.00
57.00	05700	CT SCAN	531	0	1,590	0	6,562	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	368	0	564	0	3,551	58.00
59.00	05900	CARDIAC CATHETERIZATION	123	0	0	0	1,004	59.00
60.00	06000	LABORATORY	8,230	0	30,418	0	26,789	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,293	0	466	0	2,084	65.00
66.00	06600	PHYSICAL THERAPY	5,108	0	1,191	0	2,316	66.00
68.00	06800	SPEECH PATHOLOGY	142	0	3	0	77	68.00
69.00	06900	ELECTROCARDIOLOGY	620	0	697	0	2,393	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	35,589	0	8,878	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	140,909	0	8,106	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	80,241	0	73.00
76.00	03950	CARDIAC REHAB	597	2,553	265	0	232	76.00
		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
91.00	09100	EMERGENCY	8,184	35,027	4,641	0	30,573	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	667	0	1,235	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	391	0	1,235	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	66,594	149,124	242,502	80,241	185,514	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MCH	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	0	0	0	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.05
194.06	07956	RHC- FOREST RIDGE	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	0	0	0	0	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	0	0	0	0	0	194.11
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)	66,594	149,124	242,502	80,241	185,514	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 2/15/2017 2:11 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	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW 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	1,299,800	0	1,299,800		30.00
31.00	03100	INTENSIVE CARE UNIT	487,140	0	487,140		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	124,078	0	124,078		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	670,623	0	670,623		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	54,096	0	54,096		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	435,271	0	435,271		54.00
57.00	05700	CT SCAN	27,302	0	27,302		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	24,570	0	24,570		58.00
59.00	05900	CARDIAC CATHETERIZATION	167,343	0	167,343		59.00
60.00	06000	LABORATORY	375,114	0	375,114		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	66,970	0	66,970		65.00
66.00	06600	PHYSICAL THERAPY	80,884	0	80,884		66.00
68.00	06800	SPEECH PATHOLOGY	7,194	0	7,194		68.00
69.00	06900	ELECTROCARDIOLOGY	7,535	0	7,535		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,581	0	55,581		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	193,017	0	193,017		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	80,241	0	80,241		73.00
76.00	03950	CARDIAC REHAB	20,672	0	20,672		76.00
		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
91.00	09100	EMERGENCY	482,749	0	482,749		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	18,833	0	18,833		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	11,277	0	11,277		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,690,290	0	4,690,290		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	29,842	0	29,842		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,446	0	17,446		192.00
194.00	07950	MCH	0	0	0		194.00
194.01	07951	RENTAL	70,196	0	70,196		194.01
194.02	07952	CMHS	0	0	0		194.02
194.03	07953	MCH	0	0	0		194.03
194.04	07954	WIC	0	0	0		194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	2,628	0	2,628		194.05
194.06	07956	RHC- FOREST RIDGE	81,050	0	81,050		194.06
194.07	07957	PHILLIPS HALL	2,453	0	2,453		194.07
194.08	07958	OB DRS	1,514	0	1,514		194.08
194.09	07959	THE WATERS	541,740	0	541,740		194.09
194.10	07960	CAMBRIDGE CITY	2,704	0	2,704		194.10
194.11	07961	WELL BEING	8,093	0	8,093		194.11
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)	5,447,956	0	5,447,956		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 2/15/2017 2:11 pm

		Cost Center Description	CAPITAL RELATED COSTS: NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS: NEW 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	NEW CAP REL COSTS-BLDG & FIXT	258,937					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		277,172				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,361	1,361	30,945,074			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,999	28,999	5,697,658	-13,863,026	58,345,286	5.00
7.00	00700	OPERATION OF PLANT	68,849	68,849	1,008,559	0	4,399,551	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,421	3,421	0	0	385,264	8.00
9.00	00900	HOUSEKEEPING	2,076	2,076	433,412	0	850,014	9.00
10.00	01000	DIETARY	7,218	7,218	222,992	0	502,149	10.00
11.00	01100	CAFETERIA	1,972	1,972	278,726	0	281,754	11.00
13.00	01300	NURSING ADMINISTRATION	3,669	3,669	1,600,795	0	2,437,563	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,153	7,153	428,415	0	1,088,261	14.00
15.00	01500	PHARMACY	1,562	1,562	0	0	2,830,772	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,301	5,301	606,467	0	1,120,056	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,435	29,435	2,603,458	0	4,272,234	30.00
31.00	03100	INTENSIVE CARE UNIT	11,601	11,601	1,145,512	0	1,821,966	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	3,068	3,068	503,036	0	775,243	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,274	16,274	1,948,959	0	3,596,583	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,559	1,559	90,442	0	160,387	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,322	11,322	1,465,027	0	2,584,282	54.00
57.00	05700	CT SCAN	438	438	147,633	0	432,810	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	535	535	85,224	0	282,820	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,866	4,866	38,300	0	951,673	59.00
60.00	06000	LABORATORY	8,261	8,261	1,644,977	0	4,079,039	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,736	1,736	330,949	0	550,926	65.00
66.00	06600	PHYSICAL THERAPY	1,247	1,247	1,238,130	0	1,858,705	66.00
68.00	06800	SPEECH PATHOLOGY	193	193	51,539	0	73,991	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	180,485	0	321,572	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,063,227	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4,209,494	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	711	711	126,925	0	199,380	76.00
		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
91.00	09100	EMERGENCY	10,568	10,568	2,197,653	0	3,835,430	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	946,665	0	1,458,174	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	333,729	0	894,048	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	233,395	233,395	25,355,667	-13,863,026	47,317,368	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,009	0	0	0	18,333	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	717,668	0	1,600,690	192.00
194.00	07950	MCH	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	19,244	0	0	86,327	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	22,861	194.05
194.06	07956	RHC- FOREST RIDGE	0	0	4,156,872	0	7,321,799	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	24,533	24,533	233,347	0	987,324	194.09
194.10	07960	CAMBRIDGE CITY	0	0	79,365	0	251,658	194.10
194.11	07961	WELL BEING	0	0	402,155	0	738,926	194.11
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)	4,704,776	743,180	8,785,270		13,863,026	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.169578	2.681295	0.283899		0.237603	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 2/15/2017 2:11 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			28,378		609,885	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000917		0.010453	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 2/15/2017 2:11 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	134,484					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,421	707,035				8.00
9.00	00900	HOUSEKEEPING	2,076	29,931	5,378			9.00
10.00	01000	DIETARY	7,218	8,039	105	7,499		10.00
11.00	01100	CAFETERIA	1,972	0	36	0	28,579	11.00
13.00	01300	NURSING ADMINISTRATION	3,669	0	62	0	1,847	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,153	0	62	0	777	14.00
15.00	01500	PHARMACY	1,562	0	31	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,301	0	44	0	1,366	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,435	142,442	1,326	5,757	4,775	30.00
31.00	03100	INTENSIVE CARE UNIT	11,601	32,100	206	1,742	1,786	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	3,068	11,907	18	0	787	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,274	126,819	470	0	3,695	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,559	2,140	38	0	141	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,322	51,328	309	0	2,592	54.00
57.00	05700	CT SCAN	438	0	0	0	228	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	535	0	0	0	158	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,866	1,674	58	0	53	59.00
60.00	06000	LABORATORY	8,261	892	139	0	3,532	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,736	0	116	0	555	65.00
66.00	06600	PHYSICAL THERAPY	1,247	15,534	635	0	2,192	66.00
68.00	06800	SPEECH PATHOLOGY	193	0	0	0	61	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	20	0	266	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	256	76.00
		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
91.00	09100	EMERGENCY	10,568	126,355	346	0	3,512	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	55	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	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	133,475	549,161	4,076	7,499	28,579	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,009	0	13	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	350	0	0	0	192.00
194.00	07950	MCH	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	1,186	0	0	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	14,936	0	0	0	194.05
194.06	07956	RHC- FOREST RIDGE	0	4,385	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	5,728	103	0	0	194.07
194.08	07958	OB DRS	0	9,465	0	0	0	194.08
194.09	07959	THE WATERS	0	123,010	0	0	0	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,444,898	615,311	1,162,080	943,383	436,320	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	40.487329	0.870270	216.080327	125.801173	15.267154	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,482,477	113,069	80,240	238,375	66,594	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 2/15/2017 2:11 pm

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	11.023445	0.159920	14.920045	31.787572	2.330173	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 2/15/2017 2:11 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	14,952					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,244,606				14.00
15.00	01500	PHARMACY	0	11,948	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,302	0	2,403		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,775	130,309	0	335		30.00
31.00	03100	INTENSIVE CARE UNIT	1,786	29,402	0	139		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0	0		42.00
43.00	04300	NURSERY	787	0	0	76		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,695	380,702	0	350		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	141	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	184,536	0	272		54.00
57.00	05700	CT SCAN	0	47,500	0	85		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	16,841	0	46		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	13		59.00
60.00	06000	LABORATORY	0	908,746	0	347		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	13,935	0	27		65.00
66.00	06600	PHYSICAL THERAPY	0	35,574	0	30		66.00
68.00	06800	SPEECH PATHOLOGY	0	87	0	1		68.00
69.00	06900	ELECTROCARDIOLOGY	0	20,823	0	31		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,063,227	0	115		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,209,494	0	105		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0		73.00
76.00	03950	CARDIAC REHAB	256	7,909	0	3		76.00
		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
91.00	09100	EMERGENCY	3,512	138,658	0	396		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	19,931	0	16		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	11,682	0	16		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,952	7,244,606	100	2,403		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	MCH	0	0	0	0		194.00
194.01	07951	RENTAL	0	0	0	0		194.01
194.02	07952	CMHS	0	0	0	0		194.02
194.03	07953	MCH	0	0	0	0		194.03
194.04	07954	WIC	0	0	0	0		194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0		194.05
194.06	07956	RHC- FOREST RIDGE	0	0	0	0		194.06
194.07	07957	PHILLIPS HALL	0	0	0	0		194.07
194.08	07958	OB DRS	0	0	0	0		194.08
194.09	07959	THE WATERS	0	0	0	0		194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0		194.10
194.11	07961	WELL BEING	0	0	0	0		194.11
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)	3,206,878	1,661,701	3,576,052	1,634,222		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	214.478197	0.229371	35,760.520000	680.075739		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	149,124	242,502	80,241	185,514		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 2/15/2017 2:11 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	9.973515	0.033473	802.410000	77.200999		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 2/15/2017 2:11 pm

Title XVIII | 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	8,968,547		8,968,547	0	8,968,547	30.00
31.00	03100	INTENSIVE CARE UNIT	3,527,760		3,527,760	0	3,527,760	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	1,330,404		1,330,404	0	1,330,404	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,496,216		6,496,216	0	6,496,216	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	304,082		304,082	0	304,082	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,035,031		4,035,031	0	4,035,031	54.00
57.00	05700	CT SCAN	625,562		625,562	0	625,562	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	409,238		409,238	0	409,238	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,398,444		1,398,444	0	1,398,444	59.00
60.00	06000	LABORATORY	5,911,858		5,911,858	4,917	5,916,775	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	807,210	0	807,210	0	807,210	65.00
66.00	06600	PHYSICAL THERAPY	2,563,585	0	2,563,585	0	2,563,585	66.00
68.00	06800	SPEECH PATHOLOGY	101,016	0	101,016	0	101,016	68.00
69.00	06900	ELECTROCARDIOLOGY	432,219		432,219	0	432,219	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,637,935		1,637,935	0	1,637,935	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,246,624		6,246,624	0	6,246,624	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,576,052		3,576,052	0	3,576,052	73.00
76.00	03950	CARDIAC REHAB	309,421		309,421	0	309,421	76.00
		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
91.00	09100	EMERGENCY	6,467,317		6,467,317	0	6,467,317	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,110,551		2,110,551		2,110,551	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,831,978		1,831,978		1,831,978	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	1,120,037		1,120,037		1,120,037	116.00
200.00		Subtotal (see instructions)	60,211,087	0	60,211,087	4,917	60,216,004	200.00
201.00		Less Observation Beds	2,110,551		2,110,551		2,110,551	201.00
202.00		Total (see instructions)	58,100,536	0	58,100,536	4,917	58,105,453	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 2/15/2017 2:11 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,368,617		8,368,617			30.00
31.00	03100	INTENSIVE CARE UNIT	4,472,272		4,472,272			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	770,846		770,846			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,454,318	16,786,162	23,240,480	0.279522	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	806,193	683,598	1,489,791	0.204111	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,432,675	13,760,104	15,192,779	0.265589	0.000000	54.00
57.00	05700	CT SCAN	2,391,436	19,338,906	21,730,342	0.028787	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	142,850	5,781,767	5,924,617	0.069074	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	201,288	1,529,095	1,730,383	0.808170	0.000000	59.00
60.00	06000	LABORATORY	3,839,463	18,515,685	22,355,148	0.264452	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	1,923,744	1,533,454	3,457,198	0.233487	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	621,105	3,285,168	3,906,273	0.656274	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	21,166	94,577	115,743	0.872761	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	872,910	3,060,223	3,933,133	0.109892	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,850,277	8,888,426	14,738,703	0.111132	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,453,744	3,058,730	13,512,474	0.462286	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,020,926	8,467,232	21,488,158	0.166420	0.000000	73.00
76.00	03950	CARDIAC REHAB	813	392,671	393,484	0.786362	0.000000	76.00
		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
91.00	09100	EMERGENCY	1,257,629	13,191,264	14,448,893	0.447599	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	475,931	1,319,873	1,795,804	1.175268	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,080,149	2,080,149			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	2,090,475	2,090,475			116.00
200.00		Subtotal (see instructions)	63,378,203	123,857,559	187,235,762			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	63,378,203	123,857,559	187,235,762			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 2/15/2017 2:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.279522	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.204111	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265589	54.00
57.00	05700	CT SCAN	0.028787	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.069074	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.808170	59.00
60.00	06000	LABORATORY	0.264672	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.233487	65.00
66.00	06600	PHYSICAL THERAPY	0.656274	66.00
68.00	06800	SPEECH PATHOLOGY	0.872761	68.00
69.00	06900	ELECTROCARDIOLOGY	0.109892	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.111132	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.462286	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166420	73.00
76.00	03950	CARDIAC REHAB	0.786362	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
91.00	09100	EMERGENCY	0.447599	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.175268	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: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 2/15/2017 2:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,968,547		8,968,547	0	8,968,547	30.00
31.00	03100	INTENSIVE CARE UNIT	3,527,760		3,527,760	0	3,527,760	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	1,330,404		1,330,404	0	1,330,404	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,496,216		6,496,216	0	6,496,216	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	304,082		304,082	0	304,082	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,035,031		4,035,031	0	4,035,031	54.00
57.00	05700	CT SCAN	625,562		625,562	0	625,562	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	409,238		409,238	0	409,238	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,398,444		1,398,444	0	1,398,444	59.00
60.00	06000	LABORATORY	5,911,858		5,911,858	4,917	5,916,775	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	807,210	0	807,210	0	807,210	65.00
66.00	06600	PHYSICAL THERAPY	2,563,585	0	2,563,585	0	2,563,585	66.00
68.00	06800	SPEECH PATHOLOGY	101,016	0	101,016	0	101,016	68.00
69.00	06900	ELECTROCARDIOLOGY	432,219		432,219	0	432,219	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,637,935		1,637,935	0	1,637,935	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,246,624		6,246,624	0	6,246,624	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,576,052		3,576,052	0	3,576,052	73.00
76.00	03950	CARDIAC REHAB	309,421		309,421	0	309,421	76.00
		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
91.00	09100	EMERGENCY	6,467,317		6,467,317	0	6,467,317	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,110,551		2,110,551		2,110,551	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,831,978		1,831,978		1,831,978	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	1,120,037		1,120,037		1,120,037	116.00
200.00		Subtotal (see instructions)	60,211,087	0	60,211,087	4,917	60,216,004	200.00
201.00		Less Observation Beds	2,110,551		2,110,551		2,110,551	201.00
202.00		Total (see instructions)	58,100,536	0	58,100,536	4,917	58,105,453	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 2/15/2017 2:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,368,617		8,368,617			30.00
31.00	03100	INTENSIVE CARE UNIT	4,472,272		4,472,272			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	770,846		770,846			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,454,318	16,786,162	23,240,480	0.279522	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	806,193	683,598	1,489,791	0.204111	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,432,675	13,760,104	15,192,779	0.265589	0.000000	54.00
57.00	05700	CT SCAN	2,391,436	19,338,906	21,730,342	0.028787	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	142,850	5,781,767	5,924,617	0.069074	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	201,288	1,529,095	1,730,383	0.808170	0.000000	59.00
60.00	06000	LABORATORY	3,839,463	18,515,685	22,355,148	0.264452	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	1,923,744	1,533,454	3,457,198	0.233487	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	621,105	3,285,168	3,906,273	0.656274	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	21,166	94,577	115,743	0.872761	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	872,910	3,060,223	3,933,133	0.109892	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,850,277	8,888,426	14,738,703	0.111132	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,453,744	3,058,730	13,512,474	0.462286	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,020,926	8,467,232	21,488,158	0.166420	0.000000	73.00
76.00	03950	CARDIAC REHAB	813	392,671	393,484	0.786362	0.000000	76.00
		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
91.00	09100	EMERGENCY	1,257,629	13,191,264	14,448,893	0.447599	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	475,931	1,319,873	1,795,804	1.175268	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,080,149	2,080,149			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	2,090,475	2,090,475			116.00
200.00		Subtotal (see instructions)	63,378,203	123,857,559	187,235,762			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	63,378,203	123,857,559	187,235,762			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 2/15/2017 2:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	CARDIAC REHAB	0.000000		76.00
		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
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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I Date/Time Prepared: 2/15/2017 2:11 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,299,800	0	1,299,800	7,071	183.82	30.00
31.00	INTENSIVE CARE UNIT	487,140		487,140	1,742	279.64	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	124,078		124,078	812	152.81	43.00
200.00	Total (lines 30-199)	1,911,018		1,911,018	9,625		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	2,905	533,997	30.00
31.00	INTENSIVE CARE UNIT	988	276,284	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	3,893	810,281	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 2/15/2017 2:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	670,623	23,240,480	0.028856	2,598,175	74,973	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	54,096	1,489,791	0.036311	5,970	217	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	435,271	15,192,779	0.028650	852,440	24,422	54.00
57.00	05700	CT SCAN	27,302	21,730,342	0.001256	1,466,833	1,842	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	24,570	5,924,617	0.004147	90,791	377	58.00
59.00	05900	CARDIAC CATHETERIZATION	167,343	1,730,383	0.096709	91,116	8,812	59.00
60.00	06000	LABORATORY	375,114	22,355,148	0.016780	2,017,564	33,855	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	66,970	3,457,198	0.019371	900,175	17,437	65.00
66.00	06600	PHYSICAL THERAPY	80,884	3,906,273	0.020706	351,744	7,283	66.00
68.00	06800	SPEECH PATHOLOGY	7,194	115,743	0.062155	15,097	938	68.00
69.00	06900	ELECTROCARDIOLOGY	7,535	3,933,133	0.001916	758,903	1,454	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,581	14,738,703	0.003771	2,578,922	9,725	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	193,017	13,512,474	0.014284	5,206,327	74,367	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	80,241	21,488,158	0.003734	7,639,632	28,526	73.00
76.00	03950	CARDIAC REHAB	20,672	393,484	0.052536	0	0	76.00
		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
91.00	09100	EMERGENCY	482,749	14,448,893	0.033411	506,001	16,906	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	305,880	1,795,804	0.170330	230,123	39,197	92.00
200.00		Total (lines 50-199)	3,055,042	169,453,403		25,309,813	340,331	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 2/15/2017 2:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
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	7,071	0.00	2,905	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,742	0.00	988	0		31.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
43.00	04300	NURSERY	812	0.00	0	0		43.00
200.00		Total (lines 30-199)	9,625		3,893	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 2/15/2017 2:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
		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
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: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 2/15/2017 2:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	23,240,480	0.000000	0.000000	2,598,175	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,489,791	0.000000	0.000000	5,970	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,192,779	0.000000	0.000000	852,440	54.00
57.00	05700	CT SCAN	0	21,730,342	0.000000	0.000000	1,466,833	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,924,617	0.000000	0.000000	90,791	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,730,383	0.000000	0.000000	91,116	59.00
60.00	06000	LABORATORY	0	22,355,148	0.000000	0.000000	2,017,564	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	3,457,198	0.000000	0.000000	900,175	65.00
66.00	06600	PHYSICAL THERAPY	0	3,906,273	0.000000	0.000000	351,744	66.00
68.00	06800	SPEECH PATHOLOGY	0	115,743	0.000000	0.000000	15,097	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,933,133	0.000000	0.000000	758,903	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,738,703	0.000000	0.000000	2,578,922	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	13,512,474	0.000000	0.000000	5,206,327	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,488,158	0.000000	0.000000	7,639,632	73.00
76.00	03950	CARDIAC REHAB	0	393,484	0.000000	0.000000	0	76.00
		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
91.00	09100	EMERGENCY	0	14,448,893	0.000000	0.000000	506,001	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,795,804	0.000000	0.000000	230,123	92.00
200.00		Total (lines 50-199)	0	169,453,403			25,309,813	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 2/15/2017 2:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	4,309,418	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,667,771	0		54.00
57.00	05700	CT SCAN	0	6,060,716	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,656,034	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	556,386	0		59.00
60.00	06000	LABORATORY	0	2,055,800	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	226,721	0		65.00
66.00	06600	PHYSICAL THERAPY	0	756	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,797,231	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,930,485	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	871,308	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,427,682	0		73.00
76.00	03950	CARDIAC REHAB	0	200,167	0		76.00
		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
91.00	09100	EMERGENCY	0	3,682,170	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	638,114	0		92.00
200.00		Total (lines 50-199)	0	32,080,759	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 2/15/2017 2:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.279522	4,309,418	0	0	1,204,577	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.204111	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265589	4,667,771	0	0	1,239,709	54.00
57.00	05700	CT SCAN	0.028787	6,060,716	0	0	174,470	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.069074	1,656,034	0	0	114,389	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.808170	556,386	0	0	449,654	59.00
60.00	06000	LABORATORY	0.264452	2,055,800	0	0	543,660	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.233487	226,721	0	0	52,936	65.00
66.00	06600	PHYSICAL THERAPY	0.656274	756	0	0	496	66.00
68.00	06800	SPEECH PATHOLOGY	0.872761	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.109892	1,797,231	0	0	197,501	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.111132	1,930,485	0	0	214,539	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.462286	871,308	0	0	402,793	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166420	3,427,682	0	27,376	570,435	73.00
76.00	03950	CARDIAC REHAB	0.786362	200,167	0	0	157,404	76.00
		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
91.00	09100	EMERGENCY	0.447599	3,682,170	0	0	1,648,136	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.175268	638,114	0	0	749,955	92.00
200.00		Subtotal (see instructions)		32,080,759	0	27,376	7,720,654	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		32,080,759	0	27,376	7,720,654	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 2/15/2017 2:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,556		73.00
76.00	03950	CARDIAC REHAB	0	0		76.00
		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
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	4,556		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	4,556		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 2/15/2017 2:11 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,071	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,071	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,407	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,905	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,968,547	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,968,547	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)	8,968,547	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)	1,268.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,684,586	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,684,586	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 2/15/2017 2:11 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,527,760	1,742	2,025.12	988	2,000,819	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)	6,609,327	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	12,294,732	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)	810,281	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	340,331	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,150,612	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	11,144,120	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,664	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,268.36	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,110,551	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 2/15/2017 2:11 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,299,800	8,968,547	0.144929	2,110,551	305,880	90.00
91.00	Nursing School cost	0	8,968,547	0.000000	2,110,551	0	91.00
92.00	Allied health cost	0	8,968,547	0.000000	2,110,551	0	92.00
93.00	All other Medical Education	0	8,968,547	0.000000	2,110,551	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0030	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 2/15/2017 2:11 pm
	Title XIX	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)	7,071	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,071	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,407	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	191	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)	812	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,968,547	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,968,547	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)	8,968,547	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)	1,268.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	242,257	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)	242,257	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 2/15/2017 2:11 pm

Title XIX | 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)	1,330,404	812	1,638.43	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,527,760	1,742	2,025.12	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	105,537	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	347,794	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)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,664	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,268.36	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,110,551	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 2/15/2017 2:11 pm

Title XIX | 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	1,299,800	8,968,547	0.144929	2,110,551	305,880	90.00
91.00	Nursing School cost	0	8,968,547	0.000000	2,110,551	0	91.00
92.00	Allied health cost	0	8,968,547	0.000000	2,110,551	0	92.00
93.00	All other Medical Education	0	8,968,547	0.000000	2,110,551	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 2/15/2017 2:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,631,908		30.00
31.00	03100	INTENSIVE CARE UNIT		2,409,067		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.279522	2,598,175	726,247	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.204111	5,970	1,219	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265589	852,440	226,399	54.00
57.00	05700	CT SCAN	0.028787	1,466,833	42,226	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.069074	90,791	6,271	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.808170	91,116	73,637	59.00
60.00	06000	LABORATORY	0.264672	2,017,564	533,993	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.233487	900,175	210,179	65.00
66.00	06600	PHYSICAL THERAPY	0.656274	351,744	230,840	66.00
68.00	06800	SPEECH PATHOLOGY	0.872761	15,097	13,176	68.00
69.00	06900	ELECTROCARDIOLOGY	0.109892	758,903	83,397	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.111132	2,578,922	286,601	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.462286	5,206,327	2,406,812	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166420	7,639,632	1,271,388	73.00
76.00	03950	CARDIAC REHAB	0.786362	0	0	76.00
		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
91.00	09100	EMERGENCY	0.447599	506,001	226,486	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.175268	230,123	270,456	92.00
200.00		Total (sum of lines 50-94 and 96-98)		25,309,813	6,609,327	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)		25,309,813		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 2/15/2017 2:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		264,526		30.00
31.00	03100	INTENSIVE CARE UNIT		50,747		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		79,326		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.279522	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.204111	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265589	18,153	4,821	54.00
57.00	05700	CT SCAN	0.028787	24,373	702	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.069074	3,160	218	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.808170	3,027	2,446	59.00
60.00	06000	LABORATORY	0.264452	103,511	27,374	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.233487	18,433	4,304	65.00
66.00	06600	PHYSICAL THERAPY	0.656274	4,046	2,655	66.00
68.00	06800	SPEECH PATHOLOGY	0.872761	1,066	930	68.00
69.00	06900	ELECTROCARDIOLOGY	0.109892	4,289	471	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.111132	196,292	21,814	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.462286	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166420	239,168	39,802	73.00
76.00	03950	CARDIAC REHAB	0.786362	0	0	76.00
		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
91.00	09100	EMERGENCY	0.447599	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.175268	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		615,518	105,537	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)		615,518		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 2/15/2017 2:11 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	5,942,749	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,161,586	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	126,786	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	43.44	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5.58	30.00
31.00	Percentage of Medicaid patient days (see instructions)	20.60	31.00
32.00	Sum of lines 30 and 31	26.18	32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.81	33.00
34.00	Disproportionate share adjustment (see instructions)	219,020	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Date/Time Prepared: 2/15/2017 2:11 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000061204	0.000060127	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	468,065	385,179	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	350,087	96,821	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	446,908		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	8,897,049		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	10,489,688		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	10,091,528	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	667,204	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment		54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	10,758,732	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	10,758,732	61.00
62.00	Deductibles billed to program beneficiaries	1,013,904	62.00
63.00	Coinsurance billed to program beneficiaries	10,710	63.00
64.00	Allowable bad debts (see instructions)	68,967	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	44,829	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	37,042	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	9,778,947	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	RURAL DEMONSTRATION PROJECT	0	70.50
70.88	SCH or MDH volume decrease adjustment	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	9,097	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	-6,119	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	62,393	70.93
70.94	HRR adjustment amount (see instructions)	-41,385	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 2/15/2017 2:11 pm
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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2015	621,624	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2016	293,962	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,718,519	71.00
71.01	Sequestration adjustment (see instructions)		214,370	71.01
72.00	Interim payments		10,502,588	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		1,561	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		199,243	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	893,405	301,074	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1.0061912615	1.0118431517	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	5,531	3,566	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9946	0.9957	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-4,824	-1,295	104.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/15/2017 2:11 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,942,749	0	5,942,749		5,942,749	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,161,586	0		2,161,586	2,161,586	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	126,786	0	113,825	12,961	126,786	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1081	0.1081	0.1081	0.1081		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	219,020	0	160,603	58,417	219,020	11.00
11.01	Uncompensated care payments	36.00	446,908	0	350,087	96,821	446,908	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	8,897,049	0	6,567,264	2,329,785	8,897,049	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	10,489,688	0	7,655,854	2,833,834	10,489,688	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	10,091,528	0	7,383,706	2,707,822	10,091,528	15.00
16.00	Payment for inpatient program capital	50.00	667,204	0	492,030	175,174	667,204	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/15/2017 2:11 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	7,875,736	2,882,996	10,758,732	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	648,100	0	474,921	173,179	648,100	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	19,104	0	17,109	1,995	19,104	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	667,204	0	492,030	175,174	667,204	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.078929	0.101964		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			621,624		621,624	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				293,962	293,962	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/15/2017 2:11 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,942,749	5,942,749		5,942,749	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,161,586		2,161,586	2,161,586	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	126,786	113,825	12,961	126,786	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1081	0.1081	0.1081		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	219,020	160,603	58,417	219,020	11.00
11.01	Uncompensated care payments	36.00	446,908	350,087	96,821	446,908	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	8,897,049	6,567,264	2,329,785	8,897,049	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	10,489,688	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	10,091,528	9,509,082	582,446	10,091,528	15.00
16.00	Payment for inpatient program capital	50.00	667,204	494,025	173,179	667,204	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			10,003,107	755,625	10,758,732	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/15/2017 2:11 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	648,100	474,921	173,179	648,100	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	19,104	19,104	0	19,104	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	667,204	494,025	173,179	667,204	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	621,624	621,624		621,624	28.00
29.00	Low volume adjustment on or after October 1	70.97	293,962		293,962	293,962	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	62,393	36,793	25,600	62,393	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	9,097	5,531	3,566	9,097	30.01
31.00	HRR adjustment (see instructions)	70.94	-41,385	-32,091	-9,294	-41,385	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-6,119	-4,824	-1,295	-6,119	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 2/15/2017 2:11 pm
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,556	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,720,654	2.00
3.00	PPS payments	7,318,704	3.00
4.00	Outlier payment (see instructions)	14,923	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)	4,556	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	27,376	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)	27,376	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)	27,376	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	22,820	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)	4,556	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)	7,333,627	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,617,875	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)	5,720,308	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)	5,720,308	30.00
31.00	Primary payer payments	1,809	31.00
32.00	Subtotal (line 30 minus line 31)	5,718,499	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)	290,353	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	188,729	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	239,567	36.00
37.00	Subtotal (see instructions)	5,907,228	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-106	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)	5,907,334	40.00
40.01	Sequestration adjustment (see instructions)	118,147	40.01
41.00	Interim payments	5,774,070	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	15,117	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: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/15/2017 2:11 pm

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		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		10,510,531		5,601,763	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	12/31/2015	28,160	12/31/2015	155,331	3.01
3.02			0	07/01/2015	27,700	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	08/05/2016	36,103	08/05/2016	10,724	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)		-7,943		172,307	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)		10,502,588		5,774,070	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		1,561		15,117	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		10,504,149		5,789,187	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: 15-0030	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 2/15/2017 2:11 pm
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		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	2,174	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	3,893	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	840	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	7,149	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	187,235,762	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,949,121	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)	368,786	8.00
9.00	Sequestration adjustment amount (see instructions)	7,376	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	361,410	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	323,506	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)	37,904	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 2/15/2017 2:11 pm
	Title XIX	Hospital	Cost

		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	347,794		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)	347,794	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)	347,794	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	394,599		8.00
9.00	Ancillary service charges	615,518	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)	1,010,117	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)	1,010,117	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	662,323	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)	347,794	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)	347,794	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)	347,794	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)	347,794	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	347,794	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)	347,794	0	40.00
41.00	Interim payments	385,387	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-37,593	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: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 2/15/2017 2:11 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	7,785,833	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,822,764	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	23,213	0	0	0	8.00
9.00	Other current assets	3,189,763	0	0	0	9.00
10.00	Due from other funds	72,364,988	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	93,186,561	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	46,000	0	0	0	12.00
13.00	Land improvements	1,621,597	0	0	0	13.00
14.00	Accumulated depreciation	-1,590,091	0	0	0	14.00
15.00	Buildings	36,516,120	0	0	0	15.00
16.00	Accumulated depreciation	-29,900,353	0	0	0	16.00
17.00	Leasehold improvements	2,434,464	0	0	0	17.00
18.00	Accumulated depreciation	-1,178,329	0	0	0	18.00
19.00	Fixed equipment	15,789,321	0	0	0	19.00
20.00	Accumulated depreciation	-14,189,462	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	40,870,878	0	0	0	23.00
24.00	Accumulated depreciation	-27,164,897	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)	23,255,248	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	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	21,151,329	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	21,151,329	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	137,593,138	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	27,962,713	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,217,416	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	2,929,295	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	35,109,424	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	16,328,649	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	16,328,649	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	51,438,073	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	86,155,065				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)	86,155,065	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	137,593,138	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 2/15/2017 2:11 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		80,047,495		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,107,571				2.00
3.00	Total (sum of line 1 and line 2)		86,155,066		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		86,155,066		0		11.00
12.00	MISC	1		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		86,155,065		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	MISC		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/15/2017 2:11 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	10,164,421		10,164,421	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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)	10,164,421		10,164,421	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	4,472,272		4,472,272	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)	4,472,272		4,472,272	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14,636,693		14,636,693	17.00
18.00	Ancillary services	48,032,908	105,175,798	153,208,706	18.00
19.00	Outpatient services	1,257,629	13,191,264	14,448,893	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		2,080,149	2,080,149	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	2,090,475	2,090,475	26.00
27.00	NURSERY	770,846	0	770,846	27.00
27.01	PRO FEES	4,484	7,076,318	7,080,802	27.01
27.02	OTHER	458	7,625	8,083	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	64,703,018	129,621,629	194,324,647	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		76,521,304		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)		76,521,304		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0030	Period: From 01/01/2015 To 12/31/2015	Worksheet G-3 Date/Time Prepared: 2/15/2017 2:11 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	194,324,647	1.00
2.00	Less contractual allowances and discounts on patients' accounts	116,929,434	2.00
3.00	Net patient revenues (line 1 minus line 2)	77,395,213	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	76,521,304	4.00
5.00	Net income from service to patients (line 3 minus line 4)	873,909	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	HOSPITAL OTHER REVENUE	4,830,267	24.00
24.01	HOSPITAL NON OPERATING INCOME	206,505	24.01
24.02	CATH LAB INTEREST INCOME	497	24.02
24.04	NCFIM- OTHER INCOME	417,823	24.04
24.05	NCFIM- OTHER NONOPERATING REVENUE	51,330	24.05
25.00	Total other income (sum of lines 6-24)	5,506,422	25.00
26.00	Total (line 5 plus line 25)	6,380,331	26.00
27.00	HOSPITAL OTHER EXPENSE	272,760	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	272,760	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,107,571	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H | Date/Time Prepared: 2/15/2017 2:11 pm

Home Health Agency I | PPS

		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	95,751	0	0	0	240,021	335,772	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	490,944	0	0	0	0	490,944	6.00
7.00	Physical Therapy	233,730	0	0	0	0	233,730	7.00
8.00	Occupational Therapy	85,736	0	0	0	0	85,736	8.00
9.00	Speech Pathology	184	0	0	0	0	184	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	25,150	0	0	0	0	25,150	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	931,495	0	0	0	240,021	1,171,516	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	14,854	350,626	3,047	353,673			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	490,944	0	490,944			6.00
7.00	Physical Therapy	0	233,730	0	233,730			7.00
8.00	Occupational Therapy	0	85,736	0	85,736			8.00
9.00	Speech Pathology	0	184	0	184			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	25,150	0	25,150			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	14,854	1,186,370	3,047	1,189,417			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: 15-0030 HHA CCN: 15-7430

Period: From 01/01/2015 To 12/31/2015

Worksheet H-1 Part I Date/Time Prepared: 2/15/2017 2:11 pm

Home Health Agency I

PPS

			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	353,673	0	0	0	0	353,673	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	490,944	0	0	0	0	490,944	6.00
7.00	Physical Therapy	233,730	0	0	0	0	233,730	7.00
8.00	Occupational Therapy	85,736	0	0	0	0	85,736	8.00
9.00	Speech Pathology	184	0	0	0	0	184	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	25,150	0	0	0	0	25,150	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
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,189,417	0	0	0	0	1,189,417	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	353,673		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	207,759	698,703	6.00
7.00	Physical Therapy	98,911	332,641	7.00
8.00	Occupational Therapy	36,282	122,018	8.00
9.00	Speech Pathology	78	262	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	10,643	35,793	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		1,189,417	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-1 Part II | Date/Time Prepared: 2/15/2017 2:11 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	-353,673	835,744	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	490,944	6.00
7.00	Physical Therapy	0	0	0	0	0	233,730	7.00
8.00	Occupational Therapy	0	0	0	0	0	85,736	8.00
9.00	Speech Pathology	0	0	0	0	0	184	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	25,150	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
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-353,673	835,744	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		353,673	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.423183	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0030 HHA CCN: 15-7430

Period: From 01/01/2015 To 12/31/2015

Worksheet H-2 Part I Date/Time Prepared: 2/15/2017 2:11 pm

Home Health Agency I

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW 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	0	268,757	268,757	63,857	1.00
2.00	Skilled Nursing Care	698,703	0	0	0	698,703	166,015	2.00
3.00	Physical Therapy	332,641	0	0	0	332,641	79,036	3.00
4.00	Occupational Therapy	122,018	0	0	0	122,018	28,992	4.00
5.00	Speech Pathology	262	0	0	0	262	62	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	35,793	0	0	0	35,793	8,505	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,189,417	0	0	268,757	1,458,174	346,467	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	0	0	11,884	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	11,884	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0030 HHA CCN: 15-7430 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part I Date/Time Prepared: 2/15/2017 2:11 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	4,572	0	10,881	359,951	0	359,951	1.00
2.00	Skilled Nursing Care	0	0	0	864,718	0	864,718	2.00
3.00	Physical Therapy	0	0	0	411,677	0	411,677	3.00
4.00	Occupational Therapy	0	0	0	151,010	0	151,010	4.00
5.00	Speech Pathology	0	0	0	324	0	324	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	44,298	0	44,298	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	4,572	0	10,881	1,831,978	0	1,831,978	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	211,448	1,076,166					2.00
3.00	Physical Therapy	100,666	512,343					3.00
4.00	Occupational Therapy	36,926	187,936					4.00
5.00	Speech Pathology	79	403					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	10,832	55,130					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
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19) (2)	359,951	1,831,978					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.	0.244527						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: 15-0030 HHA CCN: 15-7430

Period: From 01/01/2015 To 12/31/2015

Worksheet H-2 Part II Date/Time Prepared: 2/15/2017 2:11 pm

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW 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	0	946,665	0	268,757	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	698,703	0	2.00
3.00	Physical Therapy	0	0	0	0	332,641	0	3.00
4.00	Occupational Therapy	0	0	0	0	122,018	0	4.00
5.00	Speech Pathology	0	0	0	0	262	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	35,793	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	946,665		1,458,174	0	20.00
21.00	Total cost to be allocated	0	0	268,757		346,467	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.283899		0.237603	0.000000	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	55	0	0	0	19,931	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	55	0	0	0	19,931	20.00
21.00	Total cost to be allocated	0	11,884	0	0	0	4,572	21.00
22.00	Unit cost multiplier	0.000000	216.072727	0.000000	0.000000	0.000000	0.229391	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part II | Date/Time Prepared: 2/15/2017 2:11 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	16			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
19.50	Telemedicine	0	0			19.50
20.00	Total (sum of lines 1-19)	0	16			20.00
21.00	Total cost to be allocated	0	10,881			21.00
22.00	Unit cost multiplier	0.000000	680.062500			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part I | Date/Time Prepared: 2/15/2017 2:11 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,076,166		1,076,166	4,294	250.62	1.00
2.00	Physical Therapy	3.00	512,343	0	512,343	2,742	186.85	2.00
3.00	Occupational Therapy	4.00	187,936	0	187,936	740	253.97	3.00
4.00	Speech Pathology	5.00	403	0	403	35	11.51	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	55,130		55,130	834	66.10	6.00
7.00	Total (sum of lines 1-6)		1,831,978	0	1,831,978	8,645		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		34620	0	12			8.00
8.01	Skilled Nursing Care		50031	0	2,378			8.01
8.02	Skilled Nursing Care		99915	0	5			8.02
9.00	Physical Therapy		34620	0	8			9.00
9.01	Physical Therapy		50031	0	1,926			9.01
9.02	Physical Therapy		99915	0	0			9.02
10.00	Occupational Therapy		34620	0	0			10.00
10.01	Occupational Therapy		50031	0	561			10.01
10.02	Occupational Therapy		99915	0	0			10.02
11.00	Speech Pathology		34620	0	0			11.00
11.01	Speech Pathology		50031	0	41			11.01
11.02	Speech Pathology		99915	0	0			11.02
12.00	Medical Social Services		34620	0	0			12.00
12.01	Medical Social Services		50031	0	0			12.01
12.02	Medical Social Services		99915	0	0			12.02
13.00	Home Health Aide		34620	0	0			13.00
13.01	Home Health Aide		50031	0	519			13.01
13.02	Home Health Aide		99915	0	0			13.02
14.00	Total (sum of lines 8-13)			0	5,450			14.00

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

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	2,395		0	600,235		1.00
2.00	Physical Therapy	0	1,934		0	361,368		2.00
3.00	Occupational Therapy	0	561		0	142,477		3.00
4.00	Speech Pathology	0	41		0	472		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	519		0	34,306		6.00
7.00	Total (sum of lines 1-6)	0	5,450		0	1,138,858		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0030 HHA CCN: 15-7430 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part I Date/Time Prepared: 2/15/2017 2:11 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
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

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

	Cost Center Description	Total Program Cost (sum of 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	600,235	1.00
2.00	Physical Therapy	361,368	2.00
3.00	Occupational Therapy	142,477	3.00
4.00	Speech Pathology	472	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	34,306	6.00
7.00	Total (sum of lines 1-6)	1,138,858	7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part II | Date/Time Prepared: 2/15/2017 2:11 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.656274	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology	68.00	0.872761	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.111132	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.166420	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/15/2017 2:11 pm

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	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	852,319	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	18,414	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	8,835	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	7,820	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	3,115	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	1	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	890,504	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	890,504	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	890,504	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	890,504	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	890,504	31.00
31.01	Sequestration adjustment (see instructions)	0	17,810	31.01
32.00	Interim payments (see instructions)	0	872,694	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 HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0030 HHA CCN: 15-7430 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-5 Date/Time Prepared: 2/15/2017 2:11 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		872,694	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			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		872,694	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			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		872,694	7.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0030
Hospice CCN: 15-1564

Period: From 01/01/2015 To 12/31/2015

Worksheet K
Date/Time Prepared: 2/15/2017 2:11 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	76,931	0	0	0	491,059	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	2,100	0	0	0	0	9.00
10.00	Nursing Care	189,770	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	38,460	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	22,556	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)	329,817	0	0	0	491,059	39.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0030 Hospice CCN: 15-1564 | Period: From 01/01/2015 To 12/31/2015 | Worksheet K | Date/Time Prepared: 2/15/2017 2:11 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	567,990	-25,775	542,215	4,202	546,417	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	2,100	0	2,100	0	2,100	9.00
10.00	Nursing Care	189,770	0	189,770	0	189,770	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	38,460	0	38,460	0	38,460	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	22,556	0	22,556	0	22,556	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)	820,876	-25,775	795,101	4,202	799,303	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 15-0030 Hospice CCN: 15-1564

Period: From 01/01/2015 To 12/31/2015

Worksheet K-1

Date/Time Prepared: 2/15/2017 2:11 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	76,931	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	189,770	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	38,460	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)	76,931	0	38,460	0	189,770	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 15-0030 Hospice CCN: 15-1564

Period: From 01/01/2015 To 12/31/2015

Worksheet K-1

Date/Time Prepared: 2/15/2017 2:11 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	76,931		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	2,100	2,100		9.00
10.00	Nursing Care		0	0	189,770		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	38,460		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		22,556	0	22,556		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	22,556	2,100	329,817		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 15-0030
Hospice CCN: 15-1564

Period: From 01/01/2015 To 12/31/2015

Worksheet K-4 Part I
Date/Time Prepared: 2/15/2017 2:11 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	546,417	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	2,100	0	0	0	0	9.00
10.00	Nursing Care	189,770	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	38,460	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	22,556	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)	799,303	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 15-0030
Hospice CCN: 15-1564

Period: From 01/01/2015 To 12/31/2015

Worksheet K-4 Part I
Date/Time Prepared: 2/15/2017 2:11 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	546,417	546,417			6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0		7.00
8.00	Inpatient - Respite Care	0	0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services	0	2,100	4,538	6,638		9.00
10.00	Nursing Care	0	189,770	410,041	599,811		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	38,460	83,101	121,561		15.00
16.00	Spiritual Counseling	0	0	0	0		16.00
17.00	Dietary Counseling	0	0	0	0		17.00
18.00	Counseling - Other	0	0	0	0		18.00
19.00	Home Health Aide and Homemaker	0	22,556	48,737	71,293		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	799,303		799,303		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 Hospice CCN: 15-1564 | Period: From 01/01/2015 To 12/31/2015 | Worksheet K-4 Part II Date/Time Prepared: 2/15/2017 2:11 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: 15-0030 Hospice CCN: 15-1564 | Period: From 01/01/2015 To 12/31/2015 | Worksheet K-4 Part II Date/Time Prepared: 2/15/2017 2:11 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	-546,417	252,886		6.00
	INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0		7.00
8.00	Inpatient - Respite Care	0	0		8.00
	VISITING SERVICES				
9.00	Physician Services	0	2,100		9.00
10.00	Nursing Care	0	189,770		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	38,460		15.00
16.00	Spiritual Counseling	0	0		16.00
17.00	Dietary Counseling	0	0		17.00
18.00	Counseling - Other	0	0		18.00
19.00	Home Health Aide and Homemaker	0	22,556		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)		546,417		39.00
40.00	Unit Cost Multiplier		2.160725		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 15-0030
Hospice CCN: 15-1564

Period: From 01/01/2015 To 12/31/2015

Worksheet K-5 Part I
Date/Time Prepared: 2/15/2017 2:11 pm

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
1.00	Administrative and General		0	0	94,745	94,745	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	6,638	0	0	0	6,638	4.00
5.00	Nursing Care	599,811	0	0	0	599,811	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	121,561	0	0	0	121,561	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	71,293	0	0	0	71,293	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)	799,303	0	0	94,745	894,048	34.00
35.00	Unit Cost Multiplier (see instructions)					0	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 15-0030
Hospice CCN: 15-1564

Period: From 01/01/2015 To 12/31/2015

Worksheet K-5 Part I
Date/Time Prepared: 2/15/2017 2:11 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	22,512	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	1,577	0	0	0	0	4.00
5.00	Nursing Care	142,517	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	28,883	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	16,939	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)	212,428	0	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: 15-0030
Hospice CCN: 15-1564

Period:
From 01/01/2015
To 12/31/2015

Worksheet K-5
Part I
Date/Time Prepared:
2/15/2017 2:11 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	0	0	2,680	0	10,881	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	2,680	0	10,881	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 15-0030
Hospice CCN: 15-1564

Period: From 01/01/2015 To 12/31/2015

Worksheet K-5 Part I
Date/Time Prepared: 2/15/2017 2:11 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	130,818					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	8,215	0	8,215	1,086	9,301	4.00
5.00	Nursing Care	742,328	0	742,328	98,169	840,497	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	150,444	0	150,444	19,895	170,339	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	88,232	0	88,232	11,668	99,900	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)	1,120,037	0	1,120,037		1,120,037	34.00
35.00	Unit Cost Multiplier (see instructions)				0.132244		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 15-0030
Hospice CCN: 15-1564

Period:
From 01/01/2015
To 12/31/2015

Worksheet K-5
Part II
Date/Time Prepared:
2/15/2017 2:11 pm

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW 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	0	333,729	0	94,745	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	6,638	4.00
5.00	Nursing Care	0	0	0	0	599,811	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	121,561	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	71,293	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	333,729		894,048	34.00
35.00	Total cost to be allocated	0	0	94,745		212,428	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.283898		0.237602	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 15-0030
Hospice CCN: 15-1564

Period:
From 01/01/2015
To 12/31/2015

Worksheet K-5
Part II
Date/Time Prepared:
2/15/2017 2:11 pm

Hospice I

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 15-0030
Hospice CCN: 15-1564

Period:
From 01/01/2015
To 12/31/2015

Worksheet K-5
Part II
Date/Time Prepared:
2/15/2017 2:11 pm

Hospice I

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	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	11,682	0	16		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	11,682	0	16		34.00
35.00	Total cost to be allocated	0	2,680	0	10,881		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.229413	0.000000	680.062500		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 15-0030
Hospice CCN: 15-1564

Period: From 01/01/2015 To 12/31/2015

Worksheet K-5 Part III
Date/Time Prepared: 2/15/2017 2:11 pm

Hospice I

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.656274	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00				2.00
3.00	SPEECH PATHOLOGY	68.00	0.872761	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.166420	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.264672	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.111132	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	CARDIAC REHAB	76.00	0.786362	0	0	10.00
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 15-0030
Hospice CCN: 15-1564

Period: From 01/01/2015 To 12/31/2015

Worksheet K-6

Date/Time Prepared: 2/15/2017 2:11 pm

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				1,120,037	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				6,217	2.00
3.00	Average cost per diem (line 1 divided by line 2)				180.16	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	5,719				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	1,030,335				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		120			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		21,619			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	3,100				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	558,496				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)			378		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			68,100		13.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0030	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 2/15/2017 2:11 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	648,100	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	19,104	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	20.55	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	667,204	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00