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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151327	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 6/24/2016 12:09 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 6/24/2016 Time: 12:09 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 SULLIVAN COUNTY COMMUNITY HOSPITAL (151327) 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.

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

____
Title

____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	75,381	128,069	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	15,140	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
200.00	Total	0	90,521	128,069	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 6/24/2016 12:06 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2200 NORTH SECTION STREET	PO Box: 10			1.00
2.00	City: SULLIVAN	State: IN	Zip Code: 47882-	County: SULLIVAN	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	SULLIVAN COUNTY COMMUNITY HOSPITAL	151327	45460	1	06/01/2005	N	O	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	SULLIVAN COUNTY COMMUNITY HOSPITAL	15Z327	45460		06/01/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	SULLIVAN COUNTY HOME HEALTH	157542	45460		07/23/2002	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 6/24/2016 12:06 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.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151327	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 6/24/2016 12:06 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: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 6/24/2016 12:06 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)	N		0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	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	Y	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 6/24/2016 12:06 pm

		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		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:	102,397	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: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 6/24/2016 12:06 pm

Line	Description	1.00	2.00	Line
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

Line	1.00	2.00	3.00	Line
	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

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

Line	Description	1.00	2.00	Line
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

Line	Description	1.00	Line
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

Line	Description	Part A	Part B	Title V	Title XIX	Line
		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

Line	Description	1.00	Line
	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

Line	Description	Name	County	State	Zip Code	CBSA	FTE/Campus	Line
		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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151327	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 6/24/2016 12:06 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	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)	N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 6/24/2016 12:06 pm

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

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

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

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

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/02/2016	Y	03/02/2016	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 6/24/2016 12:06 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.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	Y	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.		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.		35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RENEE	ESSLINGER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(317) 383-3768	RESSLINGER@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 151327	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 6/24/2016 12:06 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 MANAGING CONSULTANT		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: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 6/24/2016 12:06 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	21	7,665	46,248.00	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)		21	7,665	46,248.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	4,032.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	50,280.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 6/24/2016 12:06 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,236	60	1,937			1.00
2.00	HMO and other (see instructions)	117	197				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	424	0	424			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		27	27			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,660	87	2,388			7.00
8.00	INTENSIVE CARE UNIT	123	6	168			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		179	251			13.00
14.00	Total (see instructions)	1,783	272	2,807	0.00	235.60	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3,695	138	4,427	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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						26.25
27.00	Total (sum of lines 14-26)				0.00	235.60	27.00
28.00	Observation Bed Days		268	2,310			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			10			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 6/24/2016 12:06 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	462	25	757	1.00
2.00	HMO and other (see instructions)			36	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	462	25	757	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 151327 | Component CCN: 157542 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-4 | Date/Time Prepared: 6/24/2016 12:06 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	2,051	0	0	2,051	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	128.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent) 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	1.69	0.00	1.69	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		2.58	0.00	2.58	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		1.26	0.00	1.26	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.60	0.00	0.60	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.07	0.00	0.07	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		0.51	0.00	0.51	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.		4			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		10420			20.00
20.01			45460			20.01
20.02			50037			20.02
20.03			99915			20.03

		Full Episodes Without Outliers	Full Episodes 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	1,223	0	24	9	1,256	21.00
22.00	Skilled Nursing Visit Charges	170,389	0	3,336	1,251	174,976	22.00
23.00	Physical Therapy Visits	951	0	2	1	954	23.00
24.00	Physical Therapy Visit Charges	157,620	0	330	165	158,115	24.00
25.00	Occupational Therapy Visits	465	0	0	1	466	25.00
26.00	Occupational Therapy Visit Charges	76,975	0	0	165	77,140	26.00
27.00	Speech Pathology Visits	47	0	0	0	47	27.00
28.00	Speech Pathology Visit Charges	7,499	0	0	0	7,499	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	962	0	2	8	972	31.00
32.00	Home Health Aide Visit Charges	82,010	0	170	680	82,860	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,648	0	28	19	3,695	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)	494,493	0	3,836	2,261	500,590	35.00
36.00	Total Number of Episodes (standard/non outlier)	180		11	2	193	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	880	0	22	1	903	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-10 | Date/Time Prepared: 6/24/2016 12:06 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)	0.307041	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,552,858	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	242,779	5.00
6.00	Medicaid charges	9,944,600	6.00
7.00	Medicaid cost (line 1 times line 6)	3,053,400	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,257,763	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	26,119	9.00
10.00	Stand-alone SCHIP charges	269,562	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	82,767	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	56,648	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)	1,000,864	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	7,794,810	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	2,393,326	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)	1,392,462	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,706,873	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	287,121	132,540	419,661	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	88,158	40,695	128,853	21.00
22.00	Partial payment by patients approved for charity care	457	1,809	2,266	22.00
23.00	Cost of charity care (line 21 minus line 22)	87,701	38,886	126,587	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)	3,359,037	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	757,648	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,601,389	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	798,733	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	925,320	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,632,193	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A Date/Time Prepared: 6/24/2016 12:06 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		601,234	601,234	0	601,234	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		962,495	962,495	0	962,495	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	125,200	3,198,356	3,323,556	0	3,323,556	4.00
5.01	00550	IS/ACCOUNTING/MARKETING	593,523	620,309	1,213,832	-185,437	1,028,395	5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	576,441	335,896	912,337	0	912,337	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	147,668	1,941,046	2,088,714	0	2,088,714	5.03
7.00	00700	OPERATION OF PLANT	411,444	643,077	1,054,521	0	1,054,521	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	38,969	26,142	65,111	0	65,111	8.00
9.00	00900	HOUSEKEEPING	354,464	45,746	400,210	0	400,210	9.00
10.00	01000	DIETARY	310,635	258,145	568,780	0	568,780	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	286,106	38,436	324,542	0	324,542	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	129,999	5,399	135,398	0	135,398	14.00
15.00	01500	PHARMACY	352,489	918,324	1,270,813	0	1,270,813	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	333,276	43,173	376,449	0	376,449	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	584,000	584,000	0	584,000	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,587,438	75,857	1,663,295	410,713	2,074,008	30.00
31.00	03100	INTENSIVE CARE UNIT	463,903	17,083	480,986	0	480,986	31.00
43.00	04300	NURSERY	0	0	0	93,498	93,498	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	712,270	291,040	1,003,310	-162,739	840,571	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	479,246	37,720	516,966	-504,211	12,755	52.00
53.00	05300	ANESTHESIOLOGY	0	2,221	2,221	0	2,221	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	575,156	365,206	940,362	-2,719	937,643	54.00
54.01	05401	ULTRASOUND	0	247,780	247,780	0	247,780	54.01
56.00	05600	RADIOISOTOPE	0	105,818	105,818	0	105,818	56.00
60.00	06000	LABORATORY	596,591	637,704	1,234,295	0	1,234,295	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	126,385	126,385	0	126,385	63.00
64.00	06400	INTRAVENOUS THERAPY	0	27,447	27,447	0	27,447	64.00
65.00	06500	RESPIRATORY THERAPY	443,392	67,644	511,036	-23,047	487,989	65.00
66.00	06600	PHYSICAL THERAPY	596,923	15,950	612,873	0	612,873	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	136,283	15,190	151,473	0	151,473	67.00
68.00	06800	SPEECH PATHOLOGY	61,576	1,408	62,984	0	62,984	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,870	2,870	0	2,870	70.00
70.01	07001	CARDIOPULMONARY	48,879	6,695	55,574	0	55,574	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	206,499	206,499	188,505	395,004	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	218,173	218,173	0	218,173	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	832,557	616,452	1,449,009	0	1,449,009	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	395,295	82,663	477,958	0	477,958	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,589,723	13,389,583	23,979,306	-185,437	23,793,869	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	10,182	137,127	147,309	14,604	161,913	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	170,833	170,833	194.02
200.00		TOTAL (SUM OF LINES 118-199)	10,599,905	13,526,710	24,126,615	0	24,126,615	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 6/24/2016 12:06 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	0	601,234	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-110,462	852,033	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-867,888	2,455,668	4.00
5.01	00550	IS/ACCOUNTING/MARKETING	-8,857	1,019,538	5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	0	912,337	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	-736,761	1,351,953	5.03
7.00	00700	OPERATION OF PLANT	-12,150	1,042,371	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	65,111	8.00
9.00	00900	HOUSEKEEPING	0	400,210	9.00
10.00	01000	DIETARY	-106,705	462,075	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,224	325,766	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-2,210	133,188	14.00
15.00	01500	PHARMACY	-6,419	1,264,394	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-192	376,257	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-334,000	250,000	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	2,074,008	30.00
31.00	03100	INTENSIVE CARE UNIT	0	480,986	31.00
43.00	04300	NURSERY	0	93,498	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	840,571	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	12,755	52.00
53.00	05300	ANESTHESIOLOGY	0	2,221	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,262	936,381	54.00
54.01	05401	ULTRASOUND	0	247,780	54.01
56.00	05600	RADIOISOTOPE	0	105,818	56.00
60.00	06000	LABORATORY	-8,088	1,226,207	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	126,385	63.00
64.00	06400	INTRAVENOUS THERAPY	0	27,447	64.00
65.00	06500	RESPIRATORY THERAPY	0	487,989	65.00
66.00	06600	PHYSICAL THERAPY	0	612,873	66.00
66.01	06601	SPORTS THERAPY	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	151,473	67.00
68.00	06800	SPEECH PATHOLOGY	0	62,984	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,870	70.00
70.01	07001	CARDIOPULMONARY	0	55,574	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-176	394,828	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	218,173	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	0	1,449,009	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0	477,958	101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,193,946	21,599,923	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	161,913	192.00
192.01	19201	MSO CLINICS	0	0	192.01
192.03	19203	FPA	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	194.00
194.01	07951	GUEST MEALS	0	0	194.01
194.02	07952	MARKETING	0	170,833	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-2,193,946	21,932,669	200.00

RECLASSIFICATIONS | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 6/24/2016 12:06 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - ADVERTISING RECLASS				
1.00	MARKETING	194.02	72,534	98,299	1.00
	0		72,534	98,299	
	B - DELIVERY ROOM RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	388,534	22,179	1.00
2.00	NURSERY	43.00	80,812	12,686	2.00
3.00		0.00	0	0	3.00
	0		469,346	34,865	
	C - OR SUPPLY COST				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	165,458	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	165,458	
	D - MOB EXPENSE RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	14,604	1.00
	0		0	14,604	
	E - OXYGEN RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	23,047	1.00
	0		0	23,047	
500.00	Grand Total: Increases		541,880	336,273	500.00

RECLASSIFICATIONS

Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 6/24/2016 12:06 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - ADVERTISING RECLASS						
1.00	IS/ACCOUNTING/MARKETING	5.01	72,534	98,299	0		1.00
	0		72,534	98,299			
	B - DELIVERY ROOM RECLASS						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	469,346	34,865	0		3.00
	0		469,346	34,865			
	C - OR SUPPLY COST						
1.00		0.00	0	0	0		1.00
2.00	OPERATING ROOM	50.00	0	162,739	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,719	0		3.00
	0		0	165,458			
	D - MOB EXPENSE RECLASS						
1.00	IS/ACCOUNTING/MARKETING	5.01	0	14,604	0		1.00
	0		0	14,604			
	E - OXYGEN RECLASS						
1.00	RESPIRATORY THERAPY	65.00	0	23,047	0		1.00
	0		0	23,047			
500.00	Grand Total: Decreases		541,880	336,273			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 6/24/2016 12:06 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	1,042,227	0	0	0	0	1.00
2.00	Land Improvements	345,187	0	0	0	123,690	2.00
3.00	Buildings and Fixtures	17,776,028	132,477	0	132,477	328,355	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,054,841	83,215	0	83,215	0	5.00
6.00	Movable Equipment	13,758,154	1,042,499	0	1,042,499	158,088	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,976,437	1,258,191	0	1,258,191	610,133	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	33,976,437	1,258,191	0	1,258,191	610,133	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,042,227	0	1.00
2.00	Land Improvements	221,497	0	2.00
3.00	Buildings and Fixtures	17,580,150	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	1,138,056	0	5.00
6.00	Movable Equipment	14,642,565	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	34,624,495	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	34,624,495	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II Date/Time Prepared: 6/24/2016 12:06 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	601,234	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	821,185	82,789	0	58,521	0	2.00
3.00	Total (sum of lines 1-2)	1,422,419	82,789	0	58,521	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	601,234	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	962,495	2.00
3.00	Total (sum of lines 1-2)	0	1,563,729	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 6/24/2016 12:06 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	19,981,930	0	19,981,930	0.577104	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	14,642,565	0	14,642,565	0.422896	0	2.00
3.00	Total (sum of lines 1-2)	34,624,495	0	34,624,495	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	601,234	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	712,765	82,789	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,313,999	82,789	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	0	0	0	0	601,234	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-2,042	58,521	0	0	852,033	2.00
3.00	Total (sum of lines 1-2)	-2,042	58,521	0	0	1,453,267	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 6/24/2016 12:06 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	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)	B	-1,047	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-365	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	7.00
8.00	Television and radio service (chapter 21)	A	-5,392	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-334,000			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	-206,451			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-106,705	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-6,419	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-192	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	*** Cost Center Deleted ***	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	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-108,420	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 6/24/2016 12:06 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	PHYSICIAN RECRUITMENT	A	-26,675	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.00
33.02	FLOWERS & PLANTS	A	-1,890	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.02
33.03	SALES TAX	A	-12,589	OTHER ADMINISTRATIVE AND GENERAL	5.03	9	33.03
33.05	LOBBYING EXPENSES	A	-1,087	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.05
33.06	SALES OF SUPPLIES	B	-176	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.06
33.07	ATM RENTAL AND COMISSION	B	-1,464	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.07
33.08	MISC INCOME	B	-714	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.08
33.09	EDUCATION REVENUE	B	1,224	NURSING ADMINISTRATION	13.00	0	33.09
33.10	DOMESTIC HEALTHCARE CLAIMS	B	-863,236	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	MISC INCOME	B	-8,088	LABORATORY	60.00	0	33.11
33.12	HOSPITAL ASSESSMENT FEE	A	-521,463	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.12
33.13	SURETY BONDS	B	-1,335	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.13
33.14	MISC INCOME	B	-1,262	RADIOLOGY-DIAGNOSTIC	54.00	0	33.14
33.15	BOND ISSUANCE COST	A	13,800	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,193,946				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: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-1 | Date/Time Prepared: 6/24/2016 12:06 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	2.00	NEW CAP REL COSTS-MVBLE EQUI	FITNESS CENTER - PROP INSURN	0	995	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	FITNESS CENTER - HR	0	4,652	2.00
3.00	5.01	IS/ACCOUNTING/MARKETING	FITNESS CENTER - FISCAL ACCT	0	8,857	3.00
4.00	5.03	OTHER ADMINISTRATIVE AND GEN	FITNESS CENTER - ADMIN	0	6,567	4.00
4.01	7.00	OPERATION OF PLANT	FITNESS CENTER - MAINT	0	6,758	4.01
4.02	14.00	CENTRAL SERVICES & SUPPLY	FITNESS CENTER - MATERIALS M	0	2,210	4.02
4.06	5.03	OTHER ADMINISTRATIVE AND GEN	MSO	0	176,412	4.06
4.07	0.00			0	0	4.07
4.08	0.00			0	0	4.08
4.09	0.00			0	0	4.09
4.10	0.00			0	0	4.10
5.00	0		0	0	206,451	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.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office: 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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	C		0.00	FITNESS CENTER	100.00	6.00
7.00	C		0.00	FITNESS CENTER	100.00	7.00
8.00	C		0.00	FITNESS CENTER	100.00	8.00
9.00	C		0.00	FITNESS CENTER	100.00	9.00
10.00	C		0.00	FITNESS CENTER	100.00	10.00
10.01	C		0.00	FITNESS CENTER	100.00	10.01
10.02	C		0.00	FITNESS CENTER	100.00	10.02
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-1 | Date/Time Prepared: 6/24/2016 12:06 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	-995	11	1.00
2.00	-4,652	0	2.00
3.00	-8,857	0	3.00
4.00	-6,567	0	4.00
4.01	-6,758	0	4.01
4.02	-2,210	0	4.02
4.06	-176,412	0	4.06
4.07	0	0	4.07
4.08	0	0	4.08
4.09	0	0	4.09
4.10	0	0	4.10
5.00	-206,451		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.

	Type of Business	
6.00	FITNESS CENTER	6.00
7.00	FITNESS CENTER	7.00
8.00	FITNESS CENTER	8.00
9.00	FITNESS CENTER	9.00
10.00	FITNESS CENTER	10.00
10.01	FITNESS CENTER	10.01
10.02	FITNESS CENTER	10.02
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: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 6/24/2016 12:06 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	26,000	0	26,000	0	0	1.00
2.00	19.00	NONPHYSICIAN ANESTHETISTS	584,000	334,000	250,000	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			610,000	334,000	276,000		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	19.00	NONPHYSICIAN ANESTHETISTS	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			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	60.00	LABORATORY	0	0	0	0	1.00
2.00	19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	334,000	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	0	0	334,000	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 6/24/2016 12:06 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	601,234	601,234				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	852,033		852,033			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,455,668	3,580	5,073	2,464,321		4.00
5.01	00550	IS/ACCOUNTING/MARKETING	1,019,538	15,707	22,258	122,570	1,180,073	5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	912,337	13,239	18,762	135,616	1,079,954	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	1,351,953	21,708	30,763	34,741	1,439,165	5.03
7.00	00700	OPERATION OF PLANT	1,042,371	69,788	98,900	96,798	1,307,857	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	65,111	3,639	5,157	9,168	83,075	8.00
9.00	00900	HOUSEKEEPING	400,210	8,495	12,038	83,393	504,136	9.00
10.00	01000	DIETARY	462,075	16,595	23,517	73,081	575,268	10.00
11.00	01100	CAFETERIA	0	6,041	8,560	0	14,601	11.00
13.00	01300	NURSING ADMINISTRATION	325,766	3,711	5,259	67,310	402,046	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	133,188	15,489	21,951	30,584	201,212	14.00
15.00	01500	PHARMACY	1,264,394	9,416	13,344	82,928	1,370,082	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	376,257	19,609	27,788	78,408	502,062	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	250,000	0	0	0	250,000	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,074,008	103,496	146,672	464,876	2,789,052	30.00
31.00	03100	INTENSIVE CARE UNIT	480,986	27,353	38,764	109,140	656,243	31.00
43.00	04300	NURSERY	93,498	2,191	3,105	19,012	117,806	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	840,571	88,805	125,849	167,571	1,222,796	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,755	3,073	4,355	2,329	22,512	52.00
53.00	05300	ANESTHESIOLOGY	2,221	0	0	0	2,221	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	936,381	37,204	52,723	135,314	1,161,622	54.00
54.01	05401	ULTRASOUND	247,780	2,237	3,170	0	253,187	54.01
56.00	05600	RADIOISOTOPE	105,818	2,764	3,916	0	112,498	56.00
60.00	06000	LABORATORY	1,226,207	19,938	28,254	140,356	1,414,755	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	126,385	1,250	1,772	0	129,407	63.00
64.00	06400	INTRAVENOUS THERAPY	27,447	2,217	3,142	0	32,806	64.00
65.00	06500	RESPIRATORY THERAPY	487,989	16,503	23,387	104,314	632,193	65.00
66.00	06600	PHYSICAL THERAPY	612,873	26,708	37,850	140,434	817,865	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	151,473	5,679	8,047	32,062	197,261	67.00
68.00	06800	SPEECH PATHOLOGY	62,984	1,263	1,790	14,487	80,524	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,870	1,454	2,061	0	6,385	70.00
70.01	07001	CARDIOPULMONARY	55,574	7,580	10,742	11,499	85,395	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	394,828	0	0	0	394,828	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	218,173	0	0	0	218,173	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	1,449,009	39,178	55,520	195,871	1,739,578	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	477,958	0	0	92,999	570,957	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,599,923	595,910	844,489	2,444,861	21,567,595	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,468	4,914	0	8,382	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	161,913	0	0	2,395	164,308	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	170,833	1,856	2,630	17,065	192,384	194.02
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)	21,932,669	601,234	852,033	2,464,321	21,932,669	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 6/24/2016 12:06 pm

		Cost Center Description	IS/ACCOUNTING/ MARKETING	Subtotal	BUSINESS OFFICE & ADMITTING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
			5.01	5A.01	5.02	5A.02	5.03	
		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
5.01	00550	IS/ACCOUNTING/MARKETING	1,180,073					5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	61,926	1,141,880	1,141,880			5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	82,523	1,521,688	86,817	1,608,505	1,608,505	5.03
7.00	00700	OPERATION OF PLANT	74,994	1,382,851	78,896	1,461,747	115,686	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,764	87,839	5,011	92,850	7,348	8.00
9.00	00900	HOUSEKEEPING	28,908	533,044	30,412	563,456	44,593	9.00
10.00	01000	DIETARY	32,986	608,254	34,703	642,957	50,885	10.00
11.00	01100	CAFETERIA	837	15,438	881	16,319	1,292	11.00
13.00	01300	NURSING ADMINISTRATION	23,054	425,100	24,253	449,353	35,563	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,538	212,750	12,138	224,888	17,798	14.00
15.00	01500	PHARMACY	78,562	1,448,644	82,649	1,531,293	121,190	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,789	530,851	30,287	561,138	44,410	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	14,335	264,335	15,081	279,416	22,114	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	159,928	2,948,980	168,247	3,117,227	246,711	30.00
31.00	03100	INTENSIVE CARE UNIT	37,630	693,873	39,588	733,461	58,048	31.00
43.00	04300	NURSERY	6,755	124,561	7,107	131,668	10,420	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	70,116	1,292,912	73,765	1,366,677	108,162	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,291	23,803	1,358	25,161	1,991	52.00
53.00	05300	ANESTHESIOLOGY	127	2,348	134	2,482	196	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,609	1,228,231	70,074	1,298,305	102,750	54.00
54.01	05401	ULTRASOUND	14,518	267,705	15,273	282,978	22,395	54.01
56.00	05600	RADIOISOTOPE	6,451	118,949	6,786	125,735	9,951	56.00
60.00	06000	LABORATORY	81,123	1,495,878	85,344	1,581,222	125,141	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,420	136,827	7,806	144,633	11,447	63.00
64.00	06400	INTRAVENOUS THERAPY	1,881	34,687	1,979	36,666	2,902	64.00
65.00	06500	RESPIRATORY THERAPY	36,251	668,444	38,137	706,581	55,920	65.00
66.00	06600	PHYSICAL THERAPY	46,897	864,762	49,337	914,099	72,344	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	11,311	208,572	11,900	220,472	17,449	67.00
68.00	06800	SPEECH PATHOLOGY	4,617	85,141	4,858	89,999	7,123	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	366	6,751	385	7,136	565	70.00
70.01	07001	CARDIOPULMONARY	4,897	90,292	5,151	95,443	7,554	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,640	417,468	23,818	441,286	34,924	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,510	230,683	13,161	243,844	19,298	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	99,749	1,839,327	104,939	1,944,266	153,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	32,739	603,696	0	603,696	47,778	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,169,042	21,556,564	1,130,275	21,544,959	1,577,821	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,382	0	8,382	663	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	164,308	0	164,308	13,004	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	11,031	203,415	11,605	215,020	17,017	194.02
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,180,073	21,932,669	1,141,880	21,932,669	1,608,505	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 6/24/2016 12:06 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			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
5.01	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT	1,577,433					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,028	112,226				8.00
9.00	00900	HOUSEKEEPING	28,080	0	636,129			9.00
10.00	01000	DIETARY	54,855	584	22,698	771,979		10.00
11.00	01100	CAFETERIA	19,967	200	8,262	322,259	368,299	11.00
13.00	01300	NURSING ADMINISTRATION	12,267	0	5,076	0	8,715	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	51,201	0	21,186	0	8,629	14.00
15.00	01500	PHARMACY	31,125	0	12,879	0	16,941	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	64,816	0	26,820	0	22,262	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	342,113	49,618	141,564	146,105	84,503	30.00
31.00	03100	INTENSIVE CARE UNIT	90,417	3,920	37,414	9,611	21,140	31.00
43.00	04300	NURSERY	7,243	3,473	2,997	0	2,905	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	293,545	15,008	121,466	16,545	33,249	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,157	781	4,203	0	345	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	122,977	6,608	50,887	0	29,107	54.00
54.01	05401	ULTRASOUND	7,395	0	3,060	0	2,876	54.01
56.00	05600	RADIOISOTOPE	9,135	0	3,780	0	1,093	56.00
60.00	06000	LABORATORY	65,904	336	27,270	0	37,966	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,133	0	1,710	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	7,330	0	3,033	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	54,550	672	22,572	0	20,680	65.00
66.00	06600	PHYSICAL THERAPY	88,285	9,633	36,532	0	25,656	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	18,771	0	7,767	0	5,350	67.00
68.00	06800	SPEECH PATHOLOGY	4,176	0	1,728	0	2,560	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,807	0	1,989	0	0	70.00
70.01	07001	CARDIOPULMONARY	25,057	0	10,368	0	0	70.01
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
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	129,502	21,393	53,587	0	41,446	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,559,836	112,226	628,848	494,520	365,423	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,463	0	4,743	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	277,459	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	6,134	0	2,538	0	2,876	194.02
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)	1,577,433	112,226	636,129	771,979	368,299	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 6/24/2016 12:06 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
	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
5.01	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
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	510,974					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	323,702				14.00
15.00	01500	PHARMACY	0	5,561	1,718,989			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34	0	719,480		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	301,530	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	243,414	17,120	0	65,105	0	30.00
31.00	03100	INTENSIVE CARE UNIT	47,788	1,418	0	4,439	0	31.00
43.00	04300	NURSERY	6,575	1,198	0	2,139	0	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	75,125	28,932	0	60,203	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	806	270	0	481	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	22,122	301,530	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,894	0	133,463	0	54.00
54.01	05401	ULTRASOUND	0	0	0	22,222	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	4,509	0	56.00
60.00	06000	LABORATORY	0	27,238	0	123,595	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	12,708	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	5,044	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	9,370	0	21,951	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,326	0	16,303	0	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	22	0	3,559	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	64	0	793	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	424	0	70.00
70.01	07001	CARDIOPULMONARY	0	0	0	3,119	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	137,985	0	66,959	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	76,213	0	6,317	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,718,989	34,994	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	93,635	9,273	0	101,752	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	43,631	784	0	7,279	0	101.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	510,974	323,702	1,718,989	719,480	301,530	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
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	510,974	323,702	1,718,989	719,480	301,530	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 6/24/2016 12:06 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
5.01	00550	IS/ACCOUNTING/MARKETING				5.01
5.02	00540	BUSINESS OFFICE & ADMITTING				5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL				5.03
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
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	4,453,480	0	4,453,480	30.00
31.00	03100	INTENSIVE CARE UNIT	1,007,656	0	1,007,656	31.00
43.00	04300	NURSERY	168,618	0	168,618	43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,118,912	0	2,118,912	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,195	0	44,195	52.00
53.00	05300	ANESTHESIOLOGY	326,330	0	326,330	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,750,991	0	1,750,991	54.00
54.01	05401	ULTRASOUND	340,926	0	340,926	54.01
56.00	05600	RADIOISOTOPE	154,203	0	154,203	56.00
60.00	06000	LABORATORY	1,988,672	0	1,988,672	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	174,631	0	174,631	63.00
64.00	06400	INTRAVENOUS THERAPY	54,975	0	54,975	64.00
65.00	06500	RESPIRATORY THERAPY	892,296	0	892,296	65.00
66.00	06600	PHYSICAL THERAPY	1,164,178	0	1,164,178	66.00
66.01	06601	SPORTS THERAPY	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	273,390	0	273,390	67.00
68.00	06800	SPEECH PATHOLOGY	106,443	0	106,443	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,921	0	14,921	70.00
70.01	07001	CARDIOPULMONARY	141,541	0	141,541	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	681,154	0	681,154	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	345,672	0	345,672	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,753,983	0	1,753,983	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
91.00	09100	EMERGENCY	2,548,727	0	2,548,727	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	703,168	0	703,168	101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,209,062	0	21,209,062	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,251	0	25,251	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	177,312	0	177,312	192.00
192.01	19201	MSO CLINICS	0	0	0	192.01
192.03	19203	FPA	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	277,459	0	277,459	194.00
194.01	07951	GUEST MEALS	0	0	0	194.01
194.02	07952	MARKETING	243,585	0	243,585	194.02
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)	21,932,669	0	21,932,669	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 6/24/2016 12:06 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	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	3,580	5,073	8,653	8,653	4.00
5.01	00550	IS/ACCOUNTING/MARKETING	0	15,707	22,258	37,965	430	5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	0	13,239	18,762	32,001	476	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	21,708	30,763	52,471	122	5.03
7.00	00700	OPERATION OF PLANT	0	69,788	98,900	168,688	340	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,639	5,157	8,796	32	8.00
9.00	00900	HOUSEKEEPING	0	8,495	12,038	20,533	293	9.00
10.00	01000	DIETARY	0	16,595	23,517	40,112	257	10.00
11.00	01100	CAFETERIA	0	6,041	8,560	14,601	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,711	5,259	8,970	236	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	15,489	21,951	37,440	107	14.00
15.00	01500	PHARMACY	0	9,416	13,344	22,760	291	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,609	27,788	47,397	275	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	103,496	146,672	250,168	1,634	30.00
31.00	03100	INTENSIVE CARE UNIT	0	27,353	38,764	66,117	383	31.00
43.00	04300	NURSERY	0	2,191	3,105	5,296	67	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	88,805	125,849	214,654	588	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,073	4,355	7,428	8	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,204	52,723	89,927	475	54.00
54.01	05401	ULTRASOUND	0	2,237	3,170	5,407	0	54.01
56.00	05600	RADIOISOTOPE	0	2,764	3,916	6,680	0	56.00
60.00	06000	LABORATORY	0	19,938	28,254	48,192	493	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,250	1,772	3,022	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,217	3,142	5,359	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	16,503	23,387	39,890	366	65.00
66.00	06600	PHYSICAL THERAPY	0	26,708	37,850	64,558	493	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	5,679	8,047	13,726	113	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,263	1,790	3,053	51	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,454	2,061	3,515	0	70.00
70.01	07001	CARDIOPULMONARY	0	7,580	10,742	18,322	40	70.01
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
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	39,178	55,520	94,698	688	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	327	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	595,910	844,489	1,440,399	8,585	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,468	4,914	8,382	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	8	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	1,856	2,630	4,486	60	194.02
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	601,234	852,033	1,453,267	8,653	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 6/24/2016 12:06 pm

		Cost Center Description	IS/ACCOUNTING/ MARKETING	BUSINESS OFFICE & ADMITTING	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		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
5.01	00550	IS/ACCOUNTING/MARKETING	38,395					5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	2,015	34,492				5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	2,685	2,622	57,900			5.03
7.00	00700	OPERATION OF PLANT	2,440	2,383	4,165	178,016		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	155	151	265	1,357	10,756	8.00
9.00	00900	HOUSEKEEPING	941	918	1,605	3,169	0	9.00
10.00	01000	DIETARY	1,073	1,048	1,832	6,190	56	10.00
11.00	01100	CAFETERIA	27	27	46	2,253	19	11.00
13.00	01300	NURSING ADMINISTRATION	750	732	1,280	1,384	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	375	367	641	5,778	0	14.00
15.00	01500	PHARMACY	2,557	2,496	4,363	3,513	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	937	915	1,599	7,315	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	467	455	796	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,199	5,088	8,877	38,610	4,757	30.00
31.00	03100	INTENSIVE CARE UNIT	1,225	1,196	2,090	10,204	376	31.00
43.00	04300	NURSERY	220	215	375	817	333	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,282	2,228	3,894	33,127	1,438	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	42	41	72	1,146	75	52.00
53.00	05300	ANESTHESIOLOGY	4	4	7	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,168	2,116	3,699	13,878	633	54.00
54.01	05401	ULTRASOUND	472	461	806	835	0	54.01
56.00	05600	RADIOISOTOPE	210	205	358	1,031	0	56.00
60.00	06000	LABORATORY	2,640	2,577	4,505	7,437	32	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	241	236	412	466	0	63.00
64.00	06400	INTRAVENOUS THERAPY	61	60	104	827	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,180	1,152	2,013	6,156	64	65.00
66.00	06600	PHYSICAL THERAPY	1,526	1,490	2,604	9,963	923	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	368	359	628	2,118	0	67.00
68.00	06800	SPEECH PATHOLOGY	150	147	256	471	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12	12	20	542	0	70.00
70.01	07001	CARDIOPULMONARY	159	156	272	2,828	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	737	719	1,257	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	407	397	695	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	3,246	3,169	5,539	14,615	2,050	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,065	0	1,720	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	38,036	34,142	56,795	176,030	10,756	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	24	1,294	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	468	0	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	359	350	613	692	0	194.02
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)	38,395	34,492	57,900	178,016	10,756	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 6/24/2016 12:06 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		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
5.01	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	27,459					9.00
10.00	01000	DIETARY	980	51,548				10.00
11.00	01100	CAFETERIA	357	21,518	38,848			11.00
13.00	01300	NURSING ADMINISTRATION	219	0	919	14,490		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	915	0	910	0	46,533	14.00
15.00	01500	PHARMACY	556	0	1,787	0	799	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,158	0	2,348	0	5	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,109	9,756	8,916	6,904	2,461	30.00
31.00	03100	INTENSIVE CARE UNIT	1,615	642	2,230	1,355	204	31.00
43.00	04300	NURSERY	129	0	306	186	172	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,243	1,105	3,507	2,130	4,159	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	181	0	36	23	39	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,197	0	3,070	0	991	54.00
54.01	05401	ULTRASOUND	132	0	303	0	0	54.01
56.00	05600	RADIOISOTOPE	163	0	115	0	0	56.00
60.00	06000	LABORATORY	1,177	0	4,005	0	3,916	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	74	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	131	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	974	0	2,181	0	1,347	65.00
66.00	06600	PHYSICAL THERAPY	1,577	0	2,706	0	191	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	335	0	564	0	3	67.00
68.00	06800	SPEECH PATHOLOGY	75	0	270	0	9	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	86	0	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	448	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	19,835	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	10,956	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	2,313	0	4,372	2,655	1,333	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,237	113	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,144	33,021	38,545	14,490	46,533	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	205	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	18,527	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	110	0	303	0	0	194.02
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)	27,459	51,548	38,848	14,490	46,533	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 6/24/2016 12:06 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	19.00	24.00	25.00	
		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
5.01	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
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	39,122					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	61,949				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	1,718			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,607		354,086	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	382		88,019	0	31.00
43.00	04300	NURSERY	0	184		8,300	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,185		279,540	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	41		9,132	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,905		1,920	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,484		130,638	0	54.00
54.01	05401	ULTRASOUND	0	1,914		10,330	0	54.01
56.00	05600	RADIOISOTOPE	0	388		9,150	0	56.00
60.00	06000	LABORATORY	0	10,644		85,618	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,094		5,545	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	434		6,976	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,890		57,213	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,404		87,435	0	66.00
66.01	06601	SPORTS THERAPY	0	0		0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	306		18,520	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68		4,550	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	36		4,223	0	70.00
70.01	07001	CARDIOPULMONARY	0	269		22,494	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,766		28,314	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	544		12,999	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,122	3,014		42,136	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		0	0	88.00
91.00	09100	EMERGENCY	0	8,763		143,441	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	627		5,089	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,122	61,949	0	1,415,668	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		9,905	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		476	0	192.00
192.01	19201	MSO CLINICS	0	0		0	0	192.01
192.03	19203	FPA	0	0		0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0		18,527	0	194.00
194.01	07951	GUEST MEALS	0	0		0	0	194.01
194.02	07952	MARKETING	0	0		6,973	0	194.02
200.00		Cross Foot Adjustments			1,718	1,718	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	39,122	61,949	1,718	1,453,267	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 6/24/2016 12:06 pm

		Cost Center Description	Total	
			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
5.01	00550	IS/ACCOUNTING/MARKETING		5.01
5.02	00540	BUSINESS OFFICE & ADMITTING		5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL		5.03
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
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	354,086	30.00
31.00	03100	INTENSIVE CARE UNIT	88,019	31.00
43.00	04300	NURSERY	8,300	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	279,540	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,132	52.00
53.00	05300	ANESTHESIOLOGY	1,920	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	130,638	54.00
54.01	05401	ULTRASOUND	10,330	54.01
56.00	05600	RADIOISOTOPE	9,150	56.00
60.00	06000	LABORATORY	85,618	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,545	63.00
64.00	06400	INTRAVENOUS THERAPY	6,976	64.00
65.00	06500	RESPIRATORY THERAPY	57,213	65.00
66.00	06600	PHYSICAL THERAPY	87,435	66.00
66.01	06601	SPORTS THERAPY	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	18,520	67.00
68.00	06800	SPEECH PATHOLOGY	4,550	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,223	70.00
70.01	07001	CARDIOPULMONARY	22,494	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,314	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,999	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,136	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0	88.00
91.00	09100	EMERGENCY	143,441	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY	5,089	101.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,415,668	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,905	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	476	192.00
192.01	19201	MSO CLINICS	0	192.01
192.03	19203	FPA	0	192.03
194.00	07950	MEALS ON WHEELS	18,527	194.00
194.01	07951	GUEST MEALS	0	194.01
194.02	07952	MARKETING	6,973	194.02
200.00		Cross Foot Adjustments	1,718	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	1,453,267	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 6/24/2016 12:06 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	IS/ACCOUNTING/ MARKETING (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	91,372					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		91,372				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	544	544	10,474,705			4.00
5.01	00550	IS/ACCOUNTING/MARKETING	2,387	2,387	520,989	-1,180,073	20,579,906	5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	2,012	2,012	576,441	0	1,079,954	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	3,299	3,299	147,668	0	1,439,165	5.03
7.00	00700	OPERATION OF PLANT	10,606	10,606	411,444	0	1,307,857	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	553	553	38,969	0	83,075	8.00
9.00	00900	HOUSEKEEPING	1,291	1,291	354,464	0	504,136	9.00
10.00	01000	DIETARY	2,522	2,522	310,635	0	575,268	10.00
11.00	01100	CAFETERIA	918	918	0	0	14,601	11.00
13.00	01300	NURSING ADMINISTRATION	564	564	286,106	0	402,046	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,354	2,354	129,999	0	201,212	14.00
15.00	01500	PHARMACY	1,431	1,431	352,489	0	1,370,082	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,980	2,980	333,276	0	502,062	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	250,000	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,729	15,729	1,975,972	0	2,789,052	30.00
31.00	03100	INTENSIVE CARE UNIT	4,157	4,157	463,903	0	656,243	31.00
43.00	04300	NURSERY	333	333	80,812	0	117,806	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,496	13,496	712,270	0	1,222,796	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	467	467	9,900	0	22,512	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,221	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,654	5,654	575,156	0	1,161,622	54.00
54.01	05401	ULTRASOUND	340	340	0	0	253,187	54.01
56.00	05600	RADIOISOTOPE	420	420	0	0	112,498	56.00
60.00	06000	LABORATORY	3,030	3,030	596,591	0	1,414,755	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	190	190	0	0	129,407	63.00
64.00	06400	INTRAVENOUS THERAPY	337	337	0	0	32,806	64.00
65.00	06500	RESPIRATORY THERAPY	2,508	2,508	443,392	0	632,193	65.00
66.00	06600	PHYSICAL THERAPY	4,059	4,059	596,923	0	817,865	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	863	863	136,283	0	197,261	67.00
68.00	06800	SPEECH PATHOLOGY	192	192	61,576	0	80,524	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	221	221	0	0	6,385	70.00
70.01	07001	CARDIOPULMONARY	1,152	1,152	48,879	0	85,395	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	394,828	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	218,173	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	5,954	5,954	832,557	0	1,739,578	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	395,295	0	570,957	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	90,563	90,563	10,391,989	-1,180,073	20,387,522	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	527	527	0	-8,382	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	10,182	-164,308	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	282	282	72,534	0	192,384	194.02
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)	601,234	852,033	2,464,321		1,180,073	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.580068	9.324881	0.235264		0.057341	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			8,653		38,395	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000826		0.001866	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 6/24/2016 12:06 pm

		Cost Center Description	Reconciliation	BUSINESS OFFICE & ADMITTING (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5A.02	5.02	5A.03	5.03	7.00	
		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
5.01	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	-1,141,880	20,014,403				5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	1,521,688	-1,608,505	20,324,164		5.03
7.00	00700	OPERATION OF PLANT	0	1,382,851	0	1,461,747	72,524	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	87,839	0	92,850	553	8.00
9.00	00900	HOUSEKEEPING	0	533,044	0	563,456	1,291	9.00
10.00	01000	DIETARY	0	608,254	0	642,957	2,522	10.00
11.00	01100	CAFETERIA	0	15,438	0	16,319	918	11.00
13.00	01300	NURSING ADMINISTRATION	0	425,100	0	449,353	564	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	212,750	0	224,888	2,354	14.00
15.00	01500	PHARMACY	0	1,448,644	0	1,531,293	1,431	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	530,851	0	561,138	2,980	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	264,335	0	279,416	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,948,980	0	3,117,227	15,729	30.00
31.00	03100	INTENSIVE CARE UNIT	0	693,873	0	733,461	4,157	31.00
43.00	04300	NURSERY	0	124,561	0	131,668	333	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,292,912	0	1,366,677	13,496	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	23,803	0	25,161	467	52.00
53.00	05300	ANESTHESIOLOGY	0	2,348	0	2,482	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,228,231	0	1,298,305	5,654	54.00
54.01	05401	ULTRASOUND	0	267,705	0	282,978	340	54.01
56.00	05600	RADIOISOTOPE	0	118,949	0	125,735	420	56.00
60.00	06000	LABORATORY	0	1,495,878	0	1,581,222	3,030	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	136,827	0	144,633	190	63.00
64.00	06400	INTRAVENOUS THERAPY	0	34,687	0	36,666	337	64.00
65.00	06500	RESPIRATORY THERAPY	0	668,444	0	706,581	2,508	65.00
66.00	06600	PHYSICAL THERAPY	0	864,762	0	914,099	4,059	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	208,572	0	220,472	863	67.00
68.00	06800	SPEECH PATHOLOGY	0	85,141	0	89,999	192	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,751	0	7,136	221	70.00
70.01	07001	CARDIOPULMONARY	0	90,292	0	95,443	1,152	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	417,468	0	441,286	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	230,683	0	243,844	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	1,839,327	0	1,944,266	5,954	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	-603,696	0	0	603,696	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,745,576	19,810,988	-1,608,505	19,936,454	71,715	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-8,382	0	0	8,382	527	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-164,308	0	0	164,308	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	203,415	0	215,020	282	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		1,141,880		1,608,505	1,577,433	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.057053		0.079142	21.750496	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		34,492		57,900	178,016	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001723		0.002849	2.454581	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 6/24/2016 12:06 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
		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
5.01	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	117,053					8.00
9.00	00900	HOUSEKEEPING	0	70,680				9.00
10.00	01000	DIETARY	609	2,522	80,487			10.00
11.00	01100	CAFETERIA	209	918	33,599	12,805		11.00
13.00	01300	NURSING ADMINISTRATION	0	564	0	303	163,511	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,354	0	300	0	14.00
15.00	01500	PHARMACY	0	1,431	0	589	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,980	0	774	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,752	15,729	15,233	2,938	77,892	30.00
31.00	03100	INTENSIVE CARE UNIT	4,089	4,157	1,002	735	15,292	31.00
43.00	04300	NURSERY	3,622	333	0	101	2,104	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,654	13,496	1,725	1,156	24,040	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	815	467	0	12	258	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,892	5,654	0	1,012	0	54.00
54.01	05401	ULTRASOUND	0	340	0	100	0	54.01
56.00	05600	RADIOISOTOPE	0	420	0	38	0	56.00
60.00	06000	LABORATORY	350	3,030	0	1,320	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	190	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	337	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	701	2,508	0	719	0	65.00
66.00	06600	PHYSICAL THERAPY	10,047	4,059	0	892	0	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	863	0	186	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	192	0	89	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	221	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	0	1,152	0	0	0	70.01
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
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	22,313	5,954	0	1,441	29,963	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	13,962	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	117,053	69,871	51,559	12,705	163,511	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	527	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	28,928	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	282	0	100	0	194.02
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)	112,226	636,129	771,979	368,299	510,974	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.958762	9.000127	9.591350	28.762124	3.125013	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,756	27,459	51,548	38,848	14,490	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.091890	0.388497	0.640451	3.033815	0.088618	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 6/24/2016 12:06 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			14.00	15.00	16.00	19.00		
		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
5.01	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
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	926,654					14.00
15.00	01500	PHARMACY	15,919	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	98	0	69,075,741			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,008	0	6,250,496	0		30.00
31.00	03100	INTENSIVE CARE UNIT	4,060	0	426,194	0		31.00
43.00	04300	NURSERY	3,430	0	205,318	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	82,823	0	5,779,868	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	772	0	46,196	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	2,123,888	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,736	0	12,814,462	0		54.00
54.01	05401	ULTRASOUND	0	0	2,133,487	0		54.01
56.00	05600	RADIOISOTOPE	0	0	432,939	0		56.00
60.00	06000	LABORATORY	77,974	0	11,865,883	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	1,220,088	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	484,265	0		64.00
65.00	06500	RESPIRATORY THERAPY	26,824	0	2,107,390	0		65.00
66.00	06600	PHYSICAL THERAPY	3,797	0	1,565,173	0		66.00
66.01	06601	SPORTS THERAPY	0	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	64	0	341,687	0		67.00
68.00	06800	SPEECH PATHOLOGY	182	0	76,104	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	40,677	0		70.00
70.01	07001	CARDIOPULMONARY	0	0	299,456	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	395,004	0	6,428,487	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	218,173	0	606,450	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	3,359,608	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
91.00	09100	EMERGENCY	26,547	0	9,768,778	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,243	0	698,847	0		101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	926,654	100	69,075,741	100		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
192.01	19201	MSO CLINICS	0	0	0	0		192.01
192.03	19203	FPA	0	0	0	0		192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0		194.00
194.01	07951	GUEST MEALS	0	0	0	0		194.01
194.02	07952	MARKETING	0	0	0	0		194.02
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)	323,702	1,718,989	719,480	301,530		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.349323	17,189.890000	0.010416	3,015.300000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	46,533	39,122	61,949	1,718		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.050216	391.220000	0.000897	17.180000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I | Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	4,453,480		4,453,480	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,007,656		1,007,656	0	0	31.00
43.00	04300	NURSERY	168,618		168,618	0	0	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,118,912		2,118,912	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,195		44,195	0	0	52.00
53.00	05300	ANESTHESIOLOGY	326,330		326,330	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,750,991		1,750,991	0	0	54.00
54.01	05401	ULTRASOUND	340,926		340,926	0	0	54.01
56.00	05600	RADIOISOTOPE	154,203		154,203	0	0	56.00
60.00	06000	LABORATORY	1,988,672		1,988,672	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	174,631		174,631	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	54,975		54,975	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	892,296	0	892,296	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,164,178	0	1,164,178	0	0	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	273,390	0	273,390	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	106,443	0	106,443	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,921		14,921	0	0	70.00
70.01	07001	CARDIOPULMONARY	141,541		141,541	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	681,154		681,154	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	345,672		345,672	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,753,983		1,753,983	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
91.00	09100	EMERGENCY	2,548,727		2,548,727	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,200,483		2,200,483		0	92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	703,168		703,168		0	101.00
200.00		Subtotal (see instructions)	23,409,545	0	23,409,545	0	0	200.00
201.00		Less Observation Beds	2,200,483		2,200,483		0	201.00
202.00		Total (see instructions)	21,209,062	0	21,209,062	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I | Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	2,862,193		2,862,193			30.00
31.00	03100	INTENSIVE CARE UNIT	426,194		426,194			31.00
43.00	04300	NURSERY	205,318		205,318			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	661,536	5,118,332	5,779,868	0.366602	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,067	30,129	46,196	0.956685	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	604,161	1,519,727	2,123,888	0.153647	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	300,000	12,514,462	12,814,462	0.136642	0.000000	54.00
54.01	05401	ULTRASOUND	141,651	1,991,836	2,133,487	0.159798	0.000000	54.01
56.00	05600	RADIOISOTOPE	12,900	420,039	432,939	0.356177	0.000000	56.00
60.00	06000	LABORATORY	700,000	11,165,883	11,865,883	0.167596	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	425,379	794,709	1,220,088	0.143130	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	130,233	354,032	484,265	0.113523	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	542,930	1,564,460	2,107,390	0.423413	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	95,366	1,469,807	1,565,173	0.743801	0.000000	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0.000000	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	16,453	325,234	341,687	0.800118	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	11,088	65,016	76,104	1.398652	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,086	38,591	40,677	0.366817	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0	299,456	299,456	0.472660	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,895,843	4,532,644	6,428,487	0.105959	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	120,000	486,450	606,450	0.569993	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	768,917	2,590,691	3,359,608	0.522080	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
91.00	09100	EMERGENCY	47,000	9,721,778	9,768,778	0.260905	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	134,562	3,253,741	3,388,303	0.649435	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	698,847	698,847			101.00
200.00		Subtotal (see instructions)	10,119,877	58,955,864	69,075,741			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,119,877	58,955,864	69,075,741			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I | Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
66.01	06601	SPORTS THERAPY	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0.000000	70.01
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
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
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
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: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 6/24/2016 12:06 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
					Costs			
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,453,480		4,453,480	0	4,453,480	30.00
31.00	03100	INTENSIVE CARE UNIT	1,007,656		1,007,656	0	1,007,656	31.00
43.00	04300	NURSERY	168,618		168,618	0	168,618	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,118,912		2,118,912	0	2,118,912	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,195		44,195	0	44,195	52.00
53.00	05300	ANESTHESIOLOGY	326,330		326,330	0	326,330	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,750,991		1,750,991	0	1,750,991	54.00
54.01	05401	ULTRASOUND	340,926		340,926	0	340,926	54.01
56.00	05600	RADIOISOTOPE	154,203		154,203	0	154,203	56.00
60.00	06000	LABORATORY	1,988,672		1,988,672	0	1,988,672	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	174,631		174,631	0	174,631	63.00
64.00	06400	INTRAVENOUS THERAPY	54,975		54,975	0	54,975	64.00
65.00	06500	RESPIRATORY THERAPY	892,296	0	892,296	0	892,296	65.00
66.00	06600	PHYSICAL THERAPY	1,164,178	0	1,164,178	0	1,164,178	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	273,390	0	273,390	0	273,390	67.00
68.00	06800	SPEECH PATHOLOGY	106,443	0	106,443	0	106,443	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,921		14,921	0	14,921	70.00
70.01	07001	CARDIOPULMONARY	141,541		141,541	0	141,541	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	681,154		681,154	0	681,154	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	345,672		345,672	0	345,672	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,753,983		1,753,983	0	1,753,983	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
91.00	09100	EMERGENCY	2,548,727		2,548,727	0	2,548,727	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,200,483		2,200,483		2,200,483	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	703,168		703,168		703,168	101.00
200.00		Subtotal (see instructions)	23,409,545	0	23,409,545	0	23,409,545	200.00
201.00		Less Observation Beds	2,200,483		2,200,483		2,200,483	201.00
202.00		Total (see instructions)	21,209,062	0	21,209,062	0	21,209,062	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I | Date/Time Prepared: 6/24/2016 12:06 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	2,862,193		2,862,193			30.00
31.00	03100	INTENSIVE CARE UNIT	426,194		426,194			31.00
43.00	04300	NURSERY	205,318		205,318			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	661,536	5,118,332	5,779,868	0.366602	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,067	30,129	46,196	0.956685	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	604,161	1,519,727	2,123,888	0.153647	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	300,000	12,514,462	12,814,462	0.136642	0.000000	54.00
54.01	05401	ULTRASOUND	141,651	1,991,836	2,133,487	0.159798	0.000000	54.01
56.00	05600	RADIOISOTOPE	12,900	420,039	432,939	0.356177	0.000000	56.00
60.00	06000	LABORATORY	700,000	11,165,883	11,865,883	0.167596	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	425,379	794,709	1,220,088	0.143130	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	130,233	354,032	484,265	0.113523	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	542,930	1,564,460	2,107,390	0.423413	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	95,366	1,469,807	1,565,173	0.743801	0.000000	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0.000000	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	16,453	325,234	341,687	0.800118	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	11,088	65,016	76,104	1.398652	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,086	38,591	40,677	0.366817	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0	299,456	299,456	0.472660	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,895,843	4,532,644	6,428,487	0.105959	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	120,000	486,450	606,450	0.569993	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	768,917	2,590,691	3,359,608	0.522080	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
91.00	09100	EMERGENCY	47,000	9,721,778	9,768,778	0.260905	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	134,562	3,253,741	3,388,303	0.649435	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	698,847	698,847			101.00
200.00		Subtotal (see instructions)	10,119,877	58,955,864	69,075,741			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,119,877	58,955,864	69,075,741			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I | Date/Time Prepared: 6/24/2016 12:06 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
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
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
66.01	06601	SPORTS THERAPY	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0.000000	70.01
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
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
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
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	279,540	5,779,868	0.048364	290,674	14,058	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,132	46,196	0.197679	145	29	52.00
53.00	05300	ANESTHESIOLOGY	1,920	2,123,888	0.000904	130,899	118	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	130,638	12,814,462	0.010195	258,206	2,632	54.00
54.01	05401	ULTRASOUND	10,330	2,133,487	0.004842	128,772	624	54.01
56.00	05600	RADIOISOTOPE	9,150	432,939	0.021135	12,853	272	56.00
60.00	06000	LABORATORY	85,618	11,865,883	0.007215	597,992	4,315	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,545	1,220,088	0.004545	278,789	1,267	63.00
64.00	06400	INTRAVENOUS THERAPY	6,976	484,265	0.014405	344	5	64.00
65.00	06500	RESPIRATORY THERAPY	57,213	2,107,390	0.027149	299,720	8,137	65.00
66.00	06600	PHYSICAL THERAPY	87,435	1,565,173	0.055863	25,671	1,434	66.00
66.01	06601	SPORTS THERAPY	0	0	0.000000	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	18,520	341,687	0.054202	2,104	114	67.00
68.00	06800	SPEECH PATHOLOGY	4,550	76,104	0.059787	6,095	364	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,223	40,677	0.103818	2,086	217	70.00
70.01	07001	CARDIOPULMONARY	22,494	299,456	0.075116	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,314	6,428,487	0.004404	589,190	2,595	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,999	606,450	0.021435	96,325	2,065	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,136	3,359,608	0.012542	570,500	7,155	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
91.00	09100	EMERGENCY	143,441	9,768,778	0.014684	28,490	418	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	174,956	3,388,303	0.051635	11,574	598	92.00
200.00		Total (lines 50-199)	1,135,130	64,883,189		3,330,429	46,417	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	301,530	0	0	0	301,530	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	0	0	0	0	0	70.01
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
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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)	301,530	0	0	0	301,530	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,779,868	0.000000	0.000000	290,674	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	46,196	0.000000	0.000000	145	52.00
53.00	05300	ANESTHESIOLOGY	0	2,123,888	0.141971	0.000000	130,899	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,814,462	0.000000	0.000000	258,206	54.00
54.01	05401	ULTRASOUND	0	2,133,487	0.000000	0.000000	128,772	54.01
56.00	05600	RADIOISOTOPE	0	432,939	0.000000	0.000000	12,853	56.00
60.00	06000	LABORATORY	0	11,865,883	0.000000	0.000000	597,992	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,220,088	0.000000	0.000000	278,789	63.00
64.00	06400	INTRAVENOUS THERAPY	0	484,265	0.000000	0.000000	344	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,107,390	0.000000	0.000000	299,720	65.00
66.00	06600	PHYSICAL THERAPY	0	1,565,173	0.000000	0.000000	25,671	66.00
66.01	06601	SPORTS THERAPY	0	0	0.000000	0.000000	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	341,687	0.000000	0.000000	2,104	67.00
68.00	06800	SPEECH PATHOLOGY	0	76,104	0.000000	0.000000	6,095	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	40,677	0.000000	0.000000	2,086	70.00
70.01	07001	CARDIOPULMONARY	0	299,456	0.000000	0.000000	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,428,487	0.000000	0.000000	589,190	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	606,450	0.000000	0.000000	96,325	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,359,608	0.000000	0.000000	570,500	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	9,768,778	0.000000	0.000000	28,490	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,388,303	0.000000	0.000000	11,574	92.00
200.00		Total (lines 50-199)	0	64,883,189			3,330,429	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	18,584	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
66.01	06601	SPORTS THERAPY	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00		Total (lines 50-199)	18,584	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.366602	0	1,611,677	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.956685	0	580	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.153647	0	496,082	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136642	0	4,072,829	0	0	54.00
54.01	05401	ULTRASOUND	0.159798	0	527,292	0	0	54.01
56.00	05600	RADIOISOTOPE	0.356177	0	230,653	0	0	56.00
60.00	06000	LABORATORY	0.167596	0	4,291,544	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.143130	0	354,894	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.113523	0	214,534	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.423413	0	719,511	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.743801	0	554,785	0	0	66.00
66.01	06601	SPORTS THERAPY	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.800118	0	142,416	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.398652	0	9,935	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.366817	0	11,473	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.472660	0	144,035	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.105959	0	1,411,043	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.569993	0	149,419	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.522080	0	991,530	32,654	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.260905	0	2,942,534	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.649435	0	1,251,680	0	0	92.00
200.00		Subtotal (see instructions)		0	20,128,446	32,654	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	20,128,446	32,654	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	590,844	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	555	0	52.00
53.00	05300	ANESTHESIOLOGY	76,222	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	556,520	0	54.00
54.01	05401	ULTRASOUND	84,260	0	54.01
56.00	05600	RADIOISOTOPE	82,153	0	56.00
60.00	06000	LABORATORY	719,246	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	50,796	0	63.00
64.00	06400	INTRAVENOUS THERAPY	24,355	0	64.00
65.00	06500	RESPIRATORY THERAPY	304,650	0	65.00
66.00	06600	PHYSICAL THERAPY	412,650	0	66.00
66.01	06601	SPORTS THERAPY	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	113,950	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,896	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,208	0	70.00
70.01	07001	CARDIOPULMONARY	68,080	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	149,513	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	85,168	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	517,658	17,048	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	767,722	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	812,885	0	92.00
200.00		Subtotal (see instructions)	5,435,331	17,048	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	5,435,331	17,048	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151327 | Component CCN: 15Z327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.366602	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.956685	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.153647	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136642	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.159798	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.356177	0	0	0	0	56.00
60.00	06000	LABORATORY	0.167596	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.143130	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.113523	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.423413	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.743801	0	0	0	0	66.00
66.01	06601	SPORTS THERAPY	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.800118	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.398652	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.366817	0	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.472660	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.105959	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.569993	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.522080	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.260905	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.649435	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151327 | Component CCN: 15Z327

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

Worksheet D Part V

Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
66.01	06601	SPORTS THERAPY	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	CARDIOPULMONARY	0	0	70.01
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	0	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 6/24/2016 12:06 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.366602	0	150,843	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.956685	0	1,515	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.153647	0	54,793	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136642	0	518,111	0	0	54.00
54.01	05401	ULTRASOUND	0.159798	0	105,396	0	0	54.01
56.00	05600	RADIOISOTOPE	0.356177	0	9,182	0	0	56.00
60.00	06000	LABORATORY	0.167596	0	545,021	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.143130	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.113523	0	18,225	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.423413	0	81,992	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.743801	0	23,365	0	0	66.00
66.01	06601	SPORTS THERAPY	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.800118	0	6,117	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.398652	0	4,289	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.366817	0	1,043	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.472660	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.105959	0	208,175	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.569993	0	76,619	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.522080	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.260905	0	536,172	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.649435	0	163,955	0	0	92.00
200.00		Subtotal (see instructions)		0	2,504,813	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	2,504,813	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 6/24/2016 12:06 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	55,299	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,449	0	52.00
53.00	05300	ANESTHESIOLOGY	8,419	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	70,796	0	54.00
54.01	05401	ULTRASOUND	16,842	0	54.01
56.00	05600	RADIOISOTOPE	3,270	0	56.00
60.00	06000	LABORATORY	91,343	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	2,069	0	64.00
65.00	06500	RESPIRATORY THERAPY	34,716	0	65.00
66.00	06600	PHYSICAL THERAPY	17,379	0	66.00
66.01	06601	SPORTS THERAPY	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	4,894	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,999	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	383	0	70.00
70.01	07001	CARDIOPULMONARY	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,058	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	43,672	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	139,890	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	106,478	0	92.00
200.00		Subtotal (see instructions)	624,956	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	624,956	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,698	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,247	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,937	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	424	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	27	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,236	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)	424	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	145.00	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)	4,453,480	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)	3,915	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)	407,813	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,045,667	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)	4,045,667	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)	952.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,177,401	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,177,401	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,007,656	168	5,997.95	123	737,748	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)	914,518	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,829,667	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)	403,898	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)	403,898	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,310	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	952.59	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,200,483	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	354,086	4,453,480	0.079508	2,200,483	174,956	90.00
91.00	Nursing School cost	0	4,453,480	0.000000	2,200,483	0	91.00
92.00	Allied health cost	0	4,453,480	0.000000	2,200,483	0	92.00
93.00	All other Medical Education	0	4,453,480	0.000000	2,200,483	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 6/24/2016 12:06 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)	4,698	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,247	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,937	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	424	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	27	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)	60	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)	251	15.00
16.00	Nursery days (title V or XIX only)	179	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,453,480	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)	404,254	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,049,226	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)	4,049,226	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)	953.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	57,206	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)	57,206	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 6/24/2016 12:06 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)	168,618	251	671.78	179	120,249	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,007,656	168	5,997.95	6	35,988	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)	67,655	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	281,098	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)	2,310	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	953.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,202,423	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151327	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 6/24/2016 12:06 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	354,086	4,453,480	0.079508	2,202,423	175,110	90.00
91.00	Nursing School cost	0	4,453,480	0.000000	2,202,423	0	91.00
92.00	Allied health cost	0	4,453,480	0.000000	2,202,423	0	92.00
93.00	All other Medical Education	0	4,453,480	0.000000	2,202,423	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151327	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 6/24/2016 12:06 pm
	Title XVIII	Hospital	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,724,692		30.00
31.00	03100	INTENSIVE CARE UNIT		270,218		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.366602	290,674	106,562	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.956685	145	139	52.00
53.00	05300	ANESTHESIOLOGY	0.153647	130,899	20,112	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136642	258,206	35,282	54.00
54.01	05401	ULTRASOUND	0.159798	128,772	20,578	54.01
56.00	05600	RADIOISOTOPE	0.356177	12,853	4,578	56.00
60.00	06000	LABORATORY	0.167596	597,992	100,221	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.143130	278,789	39,903	63.00
64.00	06400	INTRAVENOUS THERAPY	0.113523	344	39	64.00
65.00	06500	RESPIRATORY THERAPY	0.423413	299,720	126,905	65.00
66.00	06600	PHYSICAL THERAPY	0.743801	25,671	19,094	66.00
66.01	06601	SPORTS THERAPY	0.000000	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.800118	2,104	1,683	67.00
68.00	06800	SPEECH PATHOLOGY	1.398652	6,095	8,525	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.366817	2,086	765	70.00
70.01	07001	CARDIOPULMONARY	0.472660	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.105959	589,190	62,430	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.569993	96,325	54,905	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.522080	570,500	297,847	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.260905	28,490	7,433	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.649435	11,574	7,517	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,330,429	914,518	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,330,429		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3

Component CCN: 15Z327 | Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.366602	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.956685	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.153647	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136642	5,693	778	54.00
54.01	05401	ULTRASOUND	0.159798	3,662	585	54.01
56.00	05600	RADIOISOTOPE	0.356177	0	0	56.00
60.00	06000	LABORATORY	0.167596	72,394	12,133	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.143130	16,886	2,417	63.00
64.00	06400	INTRAVENOUS THERAPY	0.113523	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.423413	53,602	22,696	65.00
66.00	06600	PHYSICAL THERAPY	0.743801	54,767	40,736	66.00
66.01	06601	SPORTS THERAPY	0.000000	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.800118	13,206	10,566	67.00
68.00	06800	SPEECH PATHOLOGY	1.398652	4,836	6,764	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.366817	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.472660	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.105959	53,834	5,704	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.569993	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.522080	114,275	59,661	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.260905	1,026	268	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.649435	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		394,181	162,308	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)		394,181		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 6/24/2016 12:06 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		90,152		30.00
31.00	03100	INTENSIVE CARE UNIT		2,186		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.366602	15,907	5,832	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.956685	580	555	52.00
53.00	05300	ANESTHESIOLOGY	0.153647	28,715	4,412	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136642	19,061	2,605	54.00
54.01	05401	ULTRASOUND	0.159798	2,839	454	54.01
56.00	05600	RADIOISOTOPE	0.356177	0	0	56.00
60.00	06000	LABORATORY	0.167596	27,637	4,632	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.143130	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.113523	4,406	500	64.00
65.00	06500	RESPIRATORY THERAPY	0.423413	19,300	8,172	65.00
66.00	06600	PHYSICAL THERAPY	0.743801	1,033	768	66.00
66.01	06601	SPORTS THERAPY	0.000000	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.800118	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.398652	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.366817	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.472660	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.105959	82,475	8,739	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.569993	22,510	12,831	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.522080	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
91.00	09100	EMERGENCY	0.260905	17,143	4,473	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.649435	21,068	13,682	92.00
200.00		Total (sum of lines 50-94 and 96-98)		262,674	67,655	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)		262,674		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part B Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,452,379	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,452,379	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,506,903	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	40,998	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,173,352	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,292,553	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,292,553	30.00
31.00	Primary payer payments	3,138	31.00
32.00	Subtotal (line 30 minus line 31)	2,289,415	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	1,097,385	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	713,300	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	850,535	36.00
37.00	Subtotal (see instructions)	3,002,715	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,002,715	40.00
40.01	Sequestration adjustment (see instructions)	60,054	40.01
41.00	Interim payments	2,814,592	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	128,069	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: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,555,149		3,212,912	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	07/01/2015	98,900		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	05/31/2016	260,601	05/31/2016	398,320	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)		-161,701		-398,320	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,393,448		2,814,592	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		75,381		128,069	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,468,829		2,942,661	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151327 | Component CCN: 15Z327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		626,303		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	05/31/2016	82,093		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)		-82,093		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		544,210		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		15,140		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		559,350		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 151327	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 6/24/2016 12:06 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	757	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,359	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	117	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,105	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	69,075,741	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	419,661	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-2
Component CCN: 15Z327 | Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	407,937	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	163,931	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	424	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	571,868	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	571,868	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	571,868	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,103	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	570,765	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	570,765	0	19.00
19.01	Sequestration adjustment (see instructions)	11,415	0	19.01
20.00	Interim payments	544,210	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	15,140	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151327	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part V Date/Time Prepared: 6/24/2016 12:06 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,829,667	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,829,667	4.00
5.00	Primary payer payments	235	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,857,729	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,857,729	19.00
20.00	Deductibles (exclude professional component)	382,864	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,474,865	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,474,865	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	68,228	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	44,348	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	37,843	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,519,213	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	2,519,213	30.00
30.01	Sequestration adjustment (see instructions)	50,384	30.01
31.00	Interim payments	2,393,448	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	75,381	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-3 Part VII Date/Time Prepared: 6/24/2016 12:06 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	281,098		1.00
2.00	Medical and other services		624,956	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	281,098	624,956	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)	281,098	624,956	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	262,674	2,504,813	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)	262,674	2,504,813	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)	262,674	2,504,813	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	1,879,857	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	18,424	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)	281,098	624,956	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)	281,098	624,956	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	18,424	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	281,098	624,956	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)	281,098	624,956	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	281,098	624,956	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)	281,098	624,956	40.00
41.00	Interim payments	281,098	624,956	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	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: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 6/24/2016 12:06 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	5,750,672	0	0	0	1.00
2.00	Temporary investments	11,037,515	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,053,468	0	0	0	4.00
5.00	Other receivable	33,169	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,273,653	0	0	0	6.00
7.00	Inventory	521,708	0	0	0	7.00
8.00	Prepaid expenses	371,134	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	20,494,013	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,042,227	0	0	0	12.00
13.00	Land improvements	345,187	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	17,435,748	0	0	0	15.00
16.00	Accumulated depreciation	-22,943,864	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	1,138,047	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	15,311,458	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,328,803	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	32,822,816	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	893,107	0	0	0	37.00
38.00	Salaries, wages, and fees payable	179,664	0	0	0	38.00
39.00	Payroll taxes payable	528,272	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	940,755	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,541,798	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,541,798	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	30,281,018				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)	30,281,018	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	32,822,816	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 Date/Time Prepared: 6/24/2016 12:06 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		29,365,824		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,802,785				2.00
3.00	Total (sum of line 1 and line 2)		31,168,609		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)		31,168,609		0		11.00
12.00	LOSS PROFIT/LOSS CLEARING	887,591		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)		887,591		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		30,281,018		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	LOSS PROFIT/LOSS CLEARING		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: 151327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/24/2016 12:06 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,810,314		2,810,314	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	328,328		328,328	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)	3,138,642		3,138,642	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	431,334		431,334	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)	431,334		431,334	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,569,976		3,569,976	17.00
18.00	Ancillary services	6,067,570	59,777,192	65,844,762	18.00
19.00	Outpatient services	0	0	0	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		698,847	698,847	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				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,637,546	60,476,039	70,113,585	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		24,126,615		29.00
30.00	EXPENSES NOT INCLUDED ON WORKSHEET A	3,359,303			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)		3,359,303		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)		27,485,918		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151327	Period: From 01/01/2015 To 12/31/2015	Worksheet G-3 Date/Time Prepared: 6/24/2016 12:06 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	70,113,585	1.00
2.00	Less contractual allowances and discounts on patients' accounts	40,961,273	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,152,312	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,485,918	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,666,394	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	40	6.00
7.00	Income from investments	42,533	7.00
8.00	Revenues from telephone and other miscellaneous communication services	69	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	184,607	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	176	16.00
17.00	Revenue from sale of drugs to other than patients	11,172	17.00
18.00	Revenue from sale of medical records and abstracts	192	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	750	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER	-103,148	24.00
25.00	Total other income (sum of lines 6-24)	136,391	25.00
26.00	Total (line 5 plus line 25)	1,802,785	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,802,785	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151327 | HHA CCN: 157542 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H | Date/Time Prepared: 6/24/2016 12:06 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	99,419	0	7,251	0	53,831	160,501	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	152,171	0	11,100	0	0	163,271	6.00
7.00	Physical Therapy	74,244	0	5,415	0	0	79,659	7.00
8.00	Occupational Therapy	35,277	0	2,573	0	0	37,850	8.00
9.00	Speech Pathology	4,077	0	297	0	0	4,374	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	30,107	0	2,196	0	0	32,303	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	395,295	0	28,832	0	53,831	477,958	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	0	160,501	0	160,501	5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	0	163,271	0	163,271	6.00
7.00	Physical Therapy	0	79,659	0	79,659	7.00
8.00	Occupational Therapy	0	37,850	0	37,850	8.00
9.00	Speech Pathology	0	4,374	0	4,374	9.00
10.00	Medical Social Services	0	0	0	0	10.00
11.00	Home Health Aide	0	32,303	0	32,303	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	477,958	0	477,958	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: 151327 | HHA CCN: 157542 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-1 Part I | Date/Time Prepared: 6/24/2016 12:06 pm

Home Health Agency I | PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
		0	1.00	2.00	3.00	4.00	4A.00	
	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	160,501	0	0	0	0	160,501	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	163,271	0	0	0	0	163,271	6.00
7.00	Physical Therapy	79,659	0	0	0	0	79,659	7.00
8.00	Occupational Therapy	37,850	0	0	0	0	37,850	8.00
9.00	Speech Pathology	4,374	0	0	0	0	4,374	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	32,303	0	0	0	0	32,303	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	477,958	0	0	0	0	477,958	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	160,501		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	82,548	245,819	6.00
7.00	Physical Therapy	40,274	119,933	7.00
8.00	Occupational Therapy	19,136	56,986	8.00
9.00	Speech Pathology	2,211	6,585	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	16,332	48,635	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		477,958	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151327 | HHA CCN: 157542 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-1 Part II | Date/Time Prepared: 6/24/2016 12:06 pm

Home Health Agency I | PPS

		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	-160,501	317,457	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	163,271	6.00
7.00	Physical Therapy	0	0	0	0	0	79,659	7.00
8.00	Occupational Therapy	0	0	0	0	0	37,850	8.00
9.00	Speech Pathology	0	0	0	0	0	4,374	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	32,303	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-160,501	317,457	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		160,501	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.505583	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151327 | HHA CCN: 157542

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

Worksheet H-2 Part I

Date/Time Prepared: 6/24/2016 12:06 pm

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	IS/ACCOUNTING/ MARKETING	
			NEW BLDG & FIXT	NEW MVBLE EQUIP				
		0	1.00	2.00	4.00	4A	5.01	
1.00	Administrative and General	0	0	0	23,390	23,390	1,341	1.00
2.00	Skilled Nursing Care	245,819	0	0	35,801	281,620	16,147	2.00
3.00	Physical Therapy	119,933	0	0	17,467	137,400	7,879	3.00
4.00	Occupational Therapy	56,986	0	0	8,299	65,285	3,744	4.00
5.00	Speech Pathology	6,585	0	0	959	7,544	433	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	48,635	0	0	7,083	55,718	3,195	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	477,958	0	0	92,999	570,957	32,739	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	Subtotal	BUSINESS OFFICE & ADMITTING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5A.01	5.02	5A.02	5.03	7.00	8.00	
1.00	Administrative and General	24,731	0	24,731	1,957	0	0	1.00
2.00	Skilled Nursing Care	297,767	0	297,767	23,567	0	0	2.00
3.00	Physical Therapy	145,279	0	145,279	11,498	0	0	3.00
4.00	Occupational Therapy	69,029	0	69,029	5,463	0	0	4.00
5.00	Speech Pathology	7,977	0	7,977	631	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	58,913	0	58,913	4,662	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	603,696	0	603,696	47,778	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.	0.000000		0.000000				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: 151327 | HHA CCN: 157542

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

Worksheet H-2 Part I

Date/Time Prepared: 6/24/2016 12:06 pm

Home Health Agency I — PPS

	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	43,631	784	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	43,631	784	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

	Cost Center Description	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		16.00	19.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	7,279	0	78,382	0	78,382		1.00
2.00	Skilled Nursing Care	0	0	321,334	0	321,334	40,313	2.00
3.00	Physical Therapy	0	0	156,777	0	156,777	19,668	3.00
4.00	Occupational Therapy	0	0	74,492	0	74,492	9,345	4.00
5.00	Speech Pathology	0	0	8,608	0	8,608	1,080	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	63,575	0	63,575	7,976	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	7,279	0	703,168	0	703,168	78,382	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.						0.125454	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: 151327 | HHA CCN: 157542

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

Worksheet H-2 Part I

Date/Time Prepared: 6/24/2016 12:06 pm

Home Health Agency I | PPS

	Cost Center Description	Total HHA Costs	
		28.00	
1.00	Administrative and General		1.00
2.00	Skilled Nursing Care	361,647	2.00
3.00	Physical Therapy	176,445	3.00
4.00	Occupational Therapy	83,837	4.00
5.00	Speech Pathology	9,688	5.00
6.00	Medical Social Services	0	6.00
7.00	Home Health Aide	71,551	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
20.00	Total (sum of lines 1-19) (2)	703,168	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 STATISTICAL BASIS

Provider CCN: 151327 | HHA CCN: 157542 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part II | Date/Time Prepared: 6/24/2016 12:06 pm

Home Health Agency I | PPS

	Cost Center Description	CAPITAL RELATED COSTS						
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	IS/ACCOUNTING/ MARKETING (ACCUM. COST)	Reconciliation	
		1.00	2.00	4.00	5A.01	5.01	5A.02	
1.00	Administrative and General	0	0	99,419	0	23,390	-24,731	1.00
2.00	Skilled Nursing Care	0	0	152,171	0	281,620	-297,767	2.00
3.00	Physical Therapy	0	0	74,244	0	137,400	-145,279	3.00
4.00	Occupational Therapy	0	0	35,277	0	65,285	-69,029	4.00
5.00	Speech Pathology	0	0	4,077	0	7,544	-7,977	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	30,107	0	55,718	-58,913	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	395,295		570,957		20.00
21.00	Total cost to be allocated	0	0	92,999		32,739		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.235265		0.057341		22.00

	Cost Center Description	BUSINESS OFFICE & ADMITTING (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5.02	5A.03	5.03	7.00	8.00	9.00	
1.00	Administrative and General	0	0	24,731	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	297,767	0	0	0	2.00
3.00	Physical Therapy	0	0	145,279	0	0	0	3.00
4.00	Occupational Therapy	0	0	69,029	0	0	0	4.00
5.00	Speech Pathology	0	0	7,977	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	58,913	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0		603,696	0	0	0	20.00
21.00	Total cost to be allocated	0		47,778	0	0	0	21.00
22.00	Unit cost multiplier	0.000000		0.079142	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151327 | HHA CCN: 157542 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part II | Date/Time Prepared: 6/24/2016 12:06 pm

Home Health Agency I | PPS

	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	13,962	2,243	0	698,847	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	13,962	2,243	0	698,847	20.00
21.00	Total cost to be allocated	0	0	43,631	784	0	7,279	21.00
22.00	Unit cost multiplier	0.000000	0.000000	3.124982	0.349532	0.000000	0.010416	22.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151327 | HHA CCN: 157542 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part I | Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (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	361,647		361,647	1,513	239.03	1.00
2.00	Physical Therapy	3.00	176,445	0	176,445	1,133	155.73	2.00
3.00	Occupational Therapy	4.00	83,837	0	83,837	539	155.54	3.00
4.00	Speech Pathology	5.00	9,688	0	9,688	81	119.60	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	71,551		71,551	1,161	61.63	6.00
7.00	Total (sum of lines 1-6)		703,168	0	703,168	4,427		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	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		10420	0	10			8.00
8.01	Skilled Nursing Care		45460	0	1,052			8.01
8.02	Skilled Nursing Care		50037	0	152			8.02
8.03	Skilled Nursing Care		99915	0	42			8.03
9.00	Physical Therapy		10420	0	12			9.00
9.01	Physical Therapy		45460	0	804			9.01
9.02	Physical Therapy		50037	0	117			9.02
9.03	Physical Therapy		99915	0	21			9.03
10.00	Occupational Therapy		10420	0	0			10.00
10.01	Occupational Therapy		45460	0	407			10.01
10.02	Occupational Therapy		50037	0	53			10.02
10.03	Occupational Therapy		99915	0	6			10.03
11.00	Speech Pathology		10420	0	0			11.00
11.01	Speech Pathology		45460	0	47			11.01
11.02	Speech Pathology		50037	0	0			11.02
11.03	Speech Pathology		99915	0	0			11.03
12.00	Medical Social Services		10420	0	0			12.00
12.01	Medical Social Services		45460	0	0			12.01
12.02	Medical Social Services		50037	0	0			12.02
12.03	Medical Social Services		99915	0	0			12.03
13.00	Home Health Aide		10420	0	0			13.00
13.01	Home Health Aide		45460	0	832			13.01
13.02	Home Health Aide		50037	0	110			13.02
13.03	Home Health Aide		99915	0	30			13.03
14.00	Total (sum of lines 8-13)			0	3,695			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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 151327 | HHA CCN: 157542 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part I | Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Home Health Agency I | PPS

	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	1,256		0	300,222		1.00
2.00	Physical Therapy	0	954		0	148,566		2.00
3.00	Occupational Therapy	0	466		0	72,482		3.00
4.00	Speech Pathology	0	47		0	5,621		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	972		0	59,904		6.00
7.00	Total (sum of lines 1-6)	0	3,695		0	586,795		7.00

	Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
8.03	Skilled Nursing Care							8.03
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
9.03	Physical Therapy							9.03
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
10.03	Occupational Therapy							10.03
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
11.03	Speech Pathology							11.03
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
12.03	Medical Social Services							12.03
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
13.03	Home Health Aide							13.03
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges Part A	Program Covered Charges Part B Not Subject to Deductibles & Coinsurance	Program Covered Charges 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	
	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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151327 | HHA CCN: 157542 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part I | Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Home Health Agency I | PPS

	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	300,222	1.00
2.00	Physical Therapy	148,566	2.00
3.00	Occupational Therapy	72,482	3.00
4.00	Speech Pathology	5,621	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	59,904	6.00
7.00	Total (sum of lines 1-6)	586,795	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
8.03	Skilled Nursing Care		8.03
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
9.02	Physical Therapy		9.02
9.03	Physical Therapy		9.03
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
10.02	Occupational Therapy		10.02
10.03	Occupational Therapy		10.03
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
11.02	Speech Pathology		11.02
11.03	Speech Pathology		11.03
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
12.02	Medical Social Services		12.02
12.03	Medical Social Services		12.03
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
13.02	Home Health Aide		13.02
13.03	Home Health Aide		13.03
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151327 | HHA CCN: 157542

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

Worksheet H-3 Part II | Date/Time Prepared: 6/24/2016 12:06 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	0.743801	0	0	col. 2, line 2.00		1.00
1.01	Physical Therapy 1	66.01	0.000000	0	0	col. 2, line 2.01		1.01
2.00	Occupational Therapy	67.00	0.800118	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	1.398652	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.105959	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.522080	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 151327 | HHA CCN: 157542 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-4 Part I-II | Date/Time Prepared: 6/24/2016 12:06 pm

Title XVIII | Home Health Agency I | PPS

		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	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	541,905	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	3,835	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	1,242	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	546,982	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	546,982	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	546,982	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	546,982	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	546,982	31.00
31.01	Sequestration adjustment (see instructions)	0	10,940	31.01
32.00	Interim payments (see instructions)	0	536,042	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151327 HHA CCN: 157542	Period: From 01/01/2015 To 12/31/2015	Worksheet H-5 Date/Time Prepared: 6/24/2016 12:06 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		536,042	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		536,042	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		536,042	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00