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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1331	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/22/2017 10:35 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/22/2017 Time: 10:35 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARRISON COUNTY HOSPITAL (15-1331) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information
ECR: Date: 5/22/2017 Time: 10:35 am
ev6NbbHAOffM4GzsxBc4dVQTLs.ts0
KpJ0d0pzKiZQSbPIpYTERgJd0aDGeZ
wI0S05AGDm0c4TNF
PI: Date: 5/22/2017 Time: 10:35 am
ZAUs4aGyFpW6qN8lcNUV4mm1yDgDH0
R78mj0oQWB:hv.Zzf.YKNll.TbtQlZ
fbZS0yEwFX0zB2kl

(Signed) Officer or Administrator of Provider(s)

Chief Financial Officer
Title

5-23-17
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	139,478	-368,343	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	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	139,478	-368,343	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: 15-1331	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/22/2017 10:32 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 245 ATWOOD ST.	PO Box:			1.00
2.00	City: CORYDON	State: IN	Zip Code: 47112-	County: HARRISON	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	HARRISON COUNTY HOSPITAL	151331	31140	1	12/15/2005	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	HARRISON COUNTY SWING BEDS	15Z331	15999		08/14/2011	N	O	O	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	HARRISON COUNTY HHA	157242	15999		12/23/1992	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)	01/01/2016	12/31/2016	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	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: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2017 10:32 am

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2017 10:32 am

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

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2017 10:32 am

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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

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

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			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:	459,715	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2017 10:32 am

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1331	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/22/2017 10:32 am

		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)	01/01/2016	12/31/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/22/2017 10:32 am

			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	06/30/2017	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	03/10/2017	Y	03/10/2017
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/22/2017 10:32 am

		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				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SEAN		TABOR		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND COMPANY				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502.992.3520		STABOR@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1331	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/22/2017 10:32 am

		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.	SR STAFF ACCOUNTANT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/22/2017 10:32 am

	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	7,686	103,056.00	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	7,686	103,056.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,464	13,032.00	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	9,150	116,088.00	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						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/22/2017 10:32 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,023	679	4,294			1.00
2.00	HMO and other (see instructions)	161	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,023	679	4,294			7.00
8.00	INTENSIVE CARE UNIT	330	61	543			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		574	1,015			13.00
14.00	Total (see instructions)	2,353	1,314	5,852	0.00	382.45	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,721	0	7,627	0.00	11.37	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						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	393.82	27.00
28.00	Observation Bed Days		331	1,363			28.00
29.00	Ambulance Trips	1,945					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/22/2017 10:32 am

	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	641	556	1,909	1.00
2.00	HMO and other (see instructions)			48	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	641	556	1,909	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						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-1331 | Component CCN: 15-7242 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-4 | Date/Time Prepared: 5/22/2017 10:32 am

Home Health Agency I | PPS

		1.00	
0.00	County		0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	135.00	0.00	92.00	227.00	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	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		0.00	0.00	0.00	5.00
6.00	Direct Nursing Service		0.00	0.00	0.00	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		31140			20.00
20.01			99915			20.01

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,169	71	61	21	1,322	21.00
22.00	Skilled Nursing Visit Charges	146,000	8,875	7,625	2,625	165,125	22.00
23.00	Physical Therapy Visits	650	16	7	18	691	23.00
24.00	Physical Therapy Visit Charges	87,780	2,112	1,014	2,556	93,462	24.00
25.00	Occupational Therapy Visits	232	8	1	7	248	25.00
26.00	Occupational Therapy Visit Charges	30,839	1,068	134	935	32,976	26.00
27.00	Speech Pathology Visits	0	0	0	0	0	27.00
28.00	Speech Pathology Visit Charges	0	0	0	0	0	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	365	88	0	7	460	31.00
32.00	Home Health Aide Visit Charges	24,915	6,600	0	525	32,040	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,416	183	69	53	2,721	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)	289,534	18,655	8,773	6,641	323,603	35.00
36.00	Total Number of Episodes (standard/non outlier)	157		26	4	187	36.00
37.00	Total Number of Outlier Episodes		4		0	4	37.00
38.00	Total Non-Routine Medical Supply Charges	43,591	1,525	9,069	23	54,208	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/22/2017 10:32 am

		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)	0.261117	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,151,702	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	3,069,849	5.00
6.00	Medicaid charges	29,570,383	6.00
7.00	Medicaid cost (line 1 times line 6)	7,721,330	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	122,535	1,374,042	1,496,577	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	31,996	358,786	390,782	21.00
22.00	Partial payment by patients approved for charity care	4,632	404,810	409,442	22.00
23.00	Cost of charity care (line 21 minus line 22)	27,364	-46,024	-18,660	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)	5,967,387	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	670,864	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	5,296,523	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,383,012	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,364,352	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,364,352	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/22/2017 10:32 am

		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		2,037,162	2,037,162	401,252	2,438,414	1.00
1.01	00101	MOB		909,156	909,156	0	909,156	1.01
1.02	00102	AMB DEPR		0	0	63,733	63,733	1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		957,214	957,214	-119,766	837,448	2.00
2.01	00201	AMB EQUIP		0	0	134,866	134,866	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	248,736	5,257,579	5,506,315	0	5,506,315	4.00
5.01	00540	OTHER A&G	1,348,687	3,328,262	4,676,949	0	4,676,949	5.01
5.02	00560	ADMITTING	416,650	31,393	448,043	0	448,043	5.02
5.03	00590	PATIENT ACCOUNTING	406,001	526,972	932,973	0	932,973	5.03
7.00	00700	OPERATION OF PLANT	231,891	1,330,550	1,562,441	0	1,562,441	7.00
7.01	00701	AMB PLANT OPS	0	44,928	44,928	0	44,928	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	24,768	253,853	278,621	0	278,621	8.00
9.00	00900	HOUSEKEEPING	454,807	171,401	626,208	0	626,208	9.00
10.00	01000	DIETARY	395,077	351,615	746,692	-418,820	327,872	10.00
11.00	01100	CAFETERIA	0	0	0	418,820	418,820	11.00
13.00	01300	NURSING ADMINISTRATION	582,302	89,779	672,081	0	672,081	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	232,284	67,027	299,311	0	299,311	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	680,504	93,702	774,206	0	774,206	16.00
17.00	01700	SOCIAL SERVICE	240,932	1,396	242,328	0	242,328	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,841,770	207,454	3,049,224	-185,492	2,863,732	30.00
31.00	03100	INTENSIVE CARE UNIT	478,683	34,651	513,334	-326	513,008	31.00
43.00	04300	NURSERY	0	243	243	185,492	185,735	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	936,601	285,743	1,222,344	0	1,222,344	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	228,405	758,532	986,937	0	986,937	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,241,792	775,745	2,017,537	0	2,017,537	54.00
60.00	06000	LABORATORY	761,122	1,270,014	2,031,136	-5,833	2,025,303	60.00
65.00	06500	RESPIRATORY THERAPY	0	492,130	492,130	-14,031	478,099	65.00
66.00	06600	PHYSICAL THERAPY	252,821	4,301	257,122	0	257,122	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	46,248	46,248	0	46,248	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	259,938	30,727	290,665	20,602	311,267	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,050,499	2,050,499	-166,891	1,883,608	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	166,891	166,891	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	353,541	1,938,812	2,292,353	0	2,292,353	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	20,149	50,982	71,131	0	71,131	90.00
90.01	09001	SENIOR CARE	127,047	148,621	275,668	0	275,668	90.01
91.00	09100	EMERGENCY	1,381,497	381,069	1,762,566	-366	1,762,200	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,894,624	621,187	2,515,811	-46	2,515,765	95.00
101.00	10100	HOME HEALTH AGENCY	604,998	161,270	766,268	0	766,268	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		480,085	480,085	-480,085	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,645,627	25,190,302	41,835,929	0	41,835,929	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	7,131,119	2,105,611	9,236,730	0	9,236,730	192.00
194.00	07950	MARKETING	62,516	309,217	371,733	0	371,733	194.00
194.01	07951	PHYSICIAN BILLING	468,684	87,325	556,009	0	556,009	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	24,307,946	27,692,455	52,000,401	0	52,000,401	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/22/2017 10:32 am

		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	-223,903	2,214,511		1.00
1.01	00101	MOB	0	909,156		1.01
1.02	00102	AMB DEPR	0	63,733		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-146,990	690,458		2.00
2.01	00201	AMB EQUIP	0	134,866		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,506,315		4.00
5.01	00540	OTHER A&G	-1,036,266	3,640,683		5.01
5.02	00560	ADMITTING	0	448,043		5.02
5.03	00590	PATIENT ACCOUNTING	0	932,973		5.03
7.00	00700	OPERATION OF PLANT	0	1,562,441		7.00
7.01	00701	AMB PLANT OPS	0	44,928		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	278,621		8.00
9.00	00900	HOUSEKEEPING	0	626,208		9.00
10.00	01000	DIETARY	-9,296	318,576		10.00
11.00	01100	CAFETERIA	-139,912	278,908		11.00
13.00	01300	NURSING ADMINISTRATION	-5,250	666,831		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	299,311		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-43,240	730,966		16.00
17.00	01700	SOCIAL SERVICE	0	242,328		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,863,732		30.00
31.00	03100	INTENSIVE CARE UNIT	0	513,008		31.00
43.00	04300	NURSERY	0	185,735		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,222,344		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	-1,002,007	-15,070		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-8,786	2,008,751		54.00
60.00	06000	LABORATORY	-3,091	2,022,212		60.00
65.00	06500	RESPIRATORY THERAPY	0	478,099		65.00
66.00	06600	PHYSICAL THERAPY	0	257,122		66.00
67.00	06700	OCCUPATIONAL THERAPY	-1,715	44,533		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	311,267		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,883,608		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	166,891		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,292,353		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-47,372	23,759		90.00
90.01	09001	SENIOR CARE	-32,962	242,706		90.01
91.00	09100	EMERGENCY	-323,562	1,438,638		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-53,633	2,462,132		95.00
101.00	10100	HOME HEALTH AGENCY	-17,064	749,204		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,095,049	38,740,880		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-727,778	8,508,952		192.00
194.00	07950	MARKETING	0	371,733		194.00
194.01	07951	PHYSICIAN BILLING	0	556,009		194.01
194.02	07952	MOB	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-3,822,827	48,177,574		200.00

RECLASSIFICATIONS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/22/2017 10:32 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EKG				
1.00	ELECTROCARDIOLOGY	69.00	6,571	14,031	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		6,571	14,031	
	B - INTEREST				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	480,085	1.00
	TOTALS		0	480,085	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	221,599	197,221	1.00
	TOTALS		221,599	197,221	
	D - NURSERY				
1.00	NURSERY	43.00	185,492	0	1.00
	TOTALS		185,492	0	
	E - OTHER CAPITAL RELATED COSTS				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	15,100	1.00
	TOTALS		0	15,100	
	F - AMBULANCE CAPITAL				
1.00	AMB DEPR	1.02	0	63,733	1.00
2.00	AMB EQUIP	2.01	0	134,866	2.00
	TOTALS		0	198,599	
	G - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	166,891	1.00
	TOTALS		0	166,891	
500.00	Grand Total: Increases		413,662	1,071,927	500.00

RECLASSIFICATIONS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/22/2017 10:32 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EKG						
1.00	INTENSIVE CARE UNIT	31.00	326	0	0		1.00
2.00	LABORATORY	60.00	5,833	0	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	14,031	0		3.00
4.00	EMERGENCY	91.00	366	0	0		4.00
5.00	AMBULANCE SERVICES	95.00	46	0	0		5.00
	TOTALS		6,571	14,031			
	B - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	480,085	11		1.00
	TOTALS		0	480,085			
	C - CAFETERIA						
1.00	DIETARY	10.00	221,599	197,221	0		1.00
	TOTALS		221,599	197,221			
	D - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	185,492	0	0		1.00
	TOTALS		185,492	0			
	E - OTHER CAPITAL RELATED COSTS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	15,100	12		1.00
	TOTALS		0	15,100			
	F - AMBULANCE CAPITAL						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	63,733	9		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	134,866	9		2.00
	TOTALS		0	198,599			
	G - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	166,891	0		1.00
	TOTALS		0	166,891			
500.00	Grand Total: Decreases		413,662	1,071,927			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 5/22/2017 10:32 am

		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	3,001,138	0	0	0	0	1.00
2.00	Land Improvements	3,316,361	63,072	0	63,072	0	2.00
3.00	Buildings and Fixtures	36,262,800	0	0	0	101,507	3.00
4.00	Building Improvements	799,691	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	23,598,526	3,350,984	0	3,350,984	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	66,978,516	3,414,056	0	3,414,056	101,507	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	66,978,516	3,414,056	0	3,414,056	101,507	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,001,138	0	1.00
2.00	Land Improvements	3,379,433	0	2.00
3.00	Buildings and Fixtures	36,161,293	0	3.00
4.00	Building Improvements	799,691	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	26,949,510	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	70,291,065	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	70,291,065	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 5/22/2017 10:32 am

	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	1,998,235	0	0	38,927	0	1.00
1.01	MOB	0	73,142	368,678	0	0	1.01
1.02	AMB DEPR	0	0	0	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	957,214	0	0	0	0	2.00
2.01	AMB EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,955,449	73,142	368,678	38,927	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	2,037,162	1.00
1.01	MOB	467,336	909,156	1.01
1.02	AMB DEPR	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	957,214	2.00
2.01	AMB EQUIP	0	0	2.01
3.00	Total (sum of lines 1-2)	467,336	3,903,532	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III | Date/Time Prepared: 5/22/2017 10:32 am

	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	43,341,555	0	43,341,555	0.616601	0	1.00
1.01	MOB	0	0	0	0.000000	0	1.01
1.02	AMB DEPR	0	0	0	0.000000	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	26,949,510	0	26,949,510	0.383399	0	2.00
2.01	AMB EQUIP	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	70,291,065	0	70,291,065	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	1,710,599	0	1.00
1.01	MOB	0	0	0	0	73,142	1.01
1.02	AMB DEPR	0	0	0	63,733	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	822,348	-13,207	2.00
2.01	AMB EQUIP	0	0	0	134,866	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	2,731,546	59,935	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	480,085	23,827	0	0	2,214,511	1.00
1.01	MOB	368,678	0	0	467,336	909,156	1.01
1.02	AMB DEPR	0	0	0	0	63,733	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-133,783	15,100	0	0	690,458	2.00
2.01	AMB EQUIP	0	0	0	0	134,866	2.01
3.00	Total (sum of lines 1-2)	714,980	38,927	0	467,336	4,012,724	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/22/2017 10:32 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-16,800	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
1.01	Investment income - MOB (chapter 2)		0	MOB	1.01	0	1.01
1.02	Investment income - AMB DEPR (chapter 2)		0	AMB DEPR	1.02	0	1.02
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-10,446	NEW CAP REL COSTS-MVBLE EQUIP	2.00	10	2.00
2.01	Investment income - AMB EQUIP (chapter 2)		0	AMB EQUIP	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-7,734	OTHER A&G	5.01	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-576,908			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-139,912	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-43,240	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
26.01	Depreciation - MOB		0	MOB	1.01	0	26.01
26.02	Depreciation - AMB DEPR		0	AMB DEPR	1.02	0	26.02
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - AMB EQUIP		0	AMB EQUIP	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/22/2017 10:32 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	-1,715	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	-133,783	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	32.00
33.00	MISC REV - OTHER A&G	B	-36,479	OTHER A&G	5.01	0	33.00
33.01	MISC REV - LABORATORY	B	-25	LABORATORY	60.00	0	33.01
33.02	MISC REV - AMBULANCE SVS	B	-39,038	AMBULANCE SERVICES	95.00	0	33.02
34.00	UNNECESSARY BORROWING	A	-12,206	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
35.00	INTEREST RATE SWAP	A	-194,897	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	35.00
36.00	NONALLOWABLE COSTS - OTHER A&G	A	-983,199	OTHER A&G	5.01	0	36.00
36.01	NONALLOWABLE COSTS-DIETARY SALES TAX	A	-9,296	DIETARY	10.00	0	36.01
37.00	PATIENT PHONE SALARIES	A	-6,687	OTHER A&G	5.01	0	37.00
37.01	PATIENT PHONE DEPRECIATION	A	-2,761	NEW CAP REL COSTS-MVBLE EQUIP	2.00	10	37.01
38.00	CRNA CONTRACTED SERVICES	A	-724,200	ANESTHESIOLOGY	53.00	0	38.00
39.00	LOBBYING EXPENSE	A	-2,075	OTHER A&G	5.01	0	39.00
40.00	RENT EXPENSE	A	-92	OTHER A&G	5.01	0	40.00
40.01	RENT EXPENSE	A	-8,786	RADIOLOGY-DIAGNOSTIC	54.00	0	40.01
40.02	RENT EXPENSE	A	-47,372	CLINIC	90.00	0	40.02
40.03	RENT EXPENSE	A	-32,962	SENIOR CARE	90.01	0	40.03
40.04	RENT EXPENSE	A	-47,372	EMERGENCY	91.00	0	40.04
40.05	RENT EXPENSE	A	-17,064	HOME HEALTH AGENCY	101.00	0	40.05
40.06	RENT EXPENSE	A	-727,778	PHYSICIANS' PRIVATE OFFICES	192.00	0	40.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,822,827				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/22/2017 10:32 am

	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	13.00	NURSING ADMINISTRATION	5,250	5,250	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	277,807	277,807	0	0	0	2.00
3.00	60.00	LABORATORY	30,664	3,066	27,598	0	0	3.00
4.00	91.00	EMERGENCY	276,190	276,190	0	0	0	4.00
5.00	95.00	AMBULANCE SERVICES	14,595	14,595	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			604,506	576,908	27,598		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	13.00	NURSING ADMINISTRATION	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	95.00	AMBULANCE SERVICES	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	13.00	NURSING ADMINISTRATION	0	0	0	5,250		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	277,807		2.00
3.00	60.00	LABORATORY	0	0	0	3,066		3.00
4.00	91.00	EMERGENCY	0	0	0	276,190		4.00
5.00	95.00	AMBULANCE SERVICES	0	0	0	14,595		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	576,908		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1331	Period: From 01/01/2016 To 12/31/2016	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/22/2017 10:32 am

		Respiratory Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.50	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	12,500.80	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	62.96	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	31.48	31.48	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	787,050	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	787,050	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	787,050	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	787,050	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/22/2017 10:32 am

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	62.96	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	787,050	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	787,050	63.00
64.00	Total cost of outside supplier services (from your records)	471,103	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/22/2017 10:32 am

		Occupational Therapy	Cost
			1.00
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	0	1.00
2.00	Line 1 multiplied by 15 hours per week	0	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	5.50	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	585.87	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	75.93	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.97	37.97	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

			1.00
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	44,485	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	44,485	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	44,485	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	44,485	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/22/2017 10:32 am

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	75.93	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	44,485	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	44,485	63.00
64.00	Total cost of outside supplier services (from your records)	46,200	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	1,715	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/22/2017 10:32 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,214,511	2,214,511				1.00
1.01	00101	MOB	909,156	0	909,156			1.01
1.02	00102	AMB DEPR	63,733	0	0	63,733		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	690,458				690,458	2.00
2.01	00201	AMB EQUIP	134,866				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,506,315	3,246	0	0	1,012	4.00
5.01	00540	OTHER A&G	3,640,683	322,958	5,200	0	100,694	5.01
5.02	00560	ADMITTING	448,043	0	0	0	0	5.02
5.03	00590	PATIENT ACCOUNTING	932,973	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	1,562,441	254,640	0	0	79,394	7.00
7.01	00701	AMB PLANT OPS	44,928	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	278,621	14,868	0	0	4,636	8.00
9.00	00900	HOUSEKEEPING	626,208	31,846	0	0	9,929	9.00
10.00	01000	DIETARY	318,576	92,666	0	0	28,892	10.00
11.00	01100	CAFETERIA	278,908	46,292	0	0	14,433	11.00
13.00	01300	NURSING ADMINISTRATION	666,831	7,791	0	0	2,429	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	299,311	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	730,966	51,697	0	0	16,119	16.00
17.00	01700	SOCIAL SERVICE	242,328	3,116	0	0	972	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,863,732	376,619	0	0	117,425	30.00
31.00	03100	INTENSIVE CARE UNIT	513,008	47,023	0	0	14,661	31.00
43.00	04300	NURSERY	185,735	9,739	0	0	3,036	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,222,344	287,654	0	0	89,687	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-15,070	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,008,751	150,709	0	0	46,989	54.00
60.00	06000	LABORATORY	2,022,212	79,210	0	0	24,697	60.00
65.00	06500	RESPIRATORY THERAPY	478,099	17,238	0	0	5,375	65.00
66.00	06600	PHYSICAL THERAPY	257,122	58,320	0	0	18,183	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,533	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	311,267	29,606	0	0	9,231	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,883,608	70,704	0	0	22,045	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	166,891	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,292,353	19,900	0	0	6,205	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	23,759	0	42,790	0	0	90.00
90.01	09001	SENIOR CARE	242,706	0	31,038	0	0	90.01
91.00	09100	EMERGENCY	1,438,638	106,462	42,790	0	33,194	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,462,132	0	0	63,733	0	95.00
101.00	10100	HOME HEALTH AGENCY	749,204	0	30,322	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	38,740,880	2,082,304	152,140	63,733	649,238	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,229	0	0	4,125	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,508,952	107,388	0	0	33,482	192.00
194.00	07950	MARKETING	371,733	3,474	0	0	1,083	194.00
194.01	07951	PHYSICIAN BILLING	556,009	8,116	0	0	2,530	194.01
194.02	07952	MOB	0	0	757,016	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	48,177,574	2,214,511	909,156	63,733	690,458	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/22/2017 10:32 am

		Cost Center Description	CAPITAL RELATED COSTS AMB EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	OTHER A&G	ADMITTING	
			2.01	4.00	4A	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP	134,866					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,510,573				4.00
5.01	00540	OTHER A&G	0	308,906	4,378,441	4,378,441		5.01
5.02	00560	ADMITTING	0	95,430	543,473	54,329	597,802	5.02
5.03	00590	PATIENT ACCOUNTING	0	92,991	1,025,964	102,562	0	5.03
7.00	00700	OPERATION OF PLANT	0	53,113	1,949,588	194,893	0	7.00
7.01	00701	AMB PLANT OPS	0	0	44,928	4,491	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,673	303,798	30,369	0	8.00
9.00	00900	HOUSEKEEPING	0	104,170	772,153	77,189	0	9.00
10.00	01000	DIETARY	0	39,734	479,868	47,970	0	10.00
11.00	01100	CAFETERIA	0	50,755	390,388	39,026	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	133,372	810,423	81,015	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	53,203	352,514	35,239	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	155,864	954,646	95,432	0	16.00
17.00	01700	SOCIAL SERVICE	0	55,184	301,600	30,150	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	608,399	3,966,175	396,483	58,517	30.00
31.00	03100	INTENSIVE CARE UNIT	0	109,564	684,256	68,402	6,695	31.00
43.00	04300	NURSERY	0	42,485	240,995	24,091	7,731	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	214,521	1,814,206	181,359	42,737	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	52,314	37,244	3,723	6,337	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	284,423	2,490,872	249,003	171,323	54.00
60.00	06000	LABORATORY	0	172,993	2,299,112	229,833	94,624	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	500,712	50,054	6,597	65.00
66.00	06600	PHYSICAL THERAPY	0	57,907	391,532	39,140	7,538	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	44,533	4,452	1,141	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	132	68.00
69.00	06900	ELECTROCARDIOLOGY	0	61,042	411,146	41,101	17,088	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,976,357	197,569	28,655	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	166,891	16,683	1,783	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	80,976	2,399,434	239,862	31,898	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4,615	71,164	7,114	961	90.00
90.01	09001	SENIOR CARE	0	29,099	302,843	30,274	2,329	90.01
91.00	09100	EMERGENCY	0	316,337	1,937,421	193,676	73,098	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	134,866	433,938	3,094,669	309,362	35,005	95.00
101.00	10100	HOME HEALTH AGENCY	0	138,570	918,096	91,778	3,613	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	134,866	3,755,578	36,055,442	3,166,624	597,802	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	17,354	1,735	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,633,328	10,283,150	1,027,981	0	192.00
194.00	07950	MARKETING	0	14,319	390,609	39,048	0	194.00
194.01	07951	PHYSICIAN BILLING	0	107,348	674,003	67,377	0	194.01
194.02	07952	MOB	0	0	757,016	75,676	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)	134,866	5,510,573	48,177,574	4,378,441	597,802	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/22/2017 10:32 am

		Cost Center Description	PATIENT ACCOUNTING	OPERATION OF PLANT	AMB PLANT OPS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.03	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER A&G						5.01
5.02	00560	ADMITTING						5.02
5.03	00590	PATIENT ACCOUNTING	1,128,526					5.03
7.00	00700	OPERATION OF PLANT	0	2,144,481				7.00
7.01	00701	AMB PLANT OPS	0	0	49,419			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,517	0	353,684		8.00
9.00	00900	HOUSEKEEPING	0	41,804	0	34,440	925,586	9.00
10.00	01000	DIETARY	0	121,640	0	28,642	54,047	10.00
11.00	01100	CAFETERIA	0	60,767	0	0	27,000	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,227	0	0	4,544	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	67,862	0	0	30,152	16.00
17.00	01700	SOCIAL SERVICE	0	4,091	0	0	1,818	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	110,485	494,381	0	140,358	219,661	30.00
31.00	03100	INTENSIVE CARE UNIT	12,641	61,726	0	0	27,426	31.00
43.00	04300	NURSERY	14,597	12,784	0	0	5,680	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	80,691	377,598	0	19,632	167,774	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	11,966	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	323,298	197,833	0	34,952	87,901	54.00
60.00	06000	LABORATORY	178,659	103,977	0	0	46,199	60.00
65.00	06500	RESPIRATORY THERAPY	12,455	22,628	0	580	10,054	65.00
66.00	06600	PHYSICAL THERAPY	14,232	76,555	0	3,065	34,015	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,154	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	249	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	32,264	38,863	0	9,029	17,268	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	54,102	92,812	0	0	41,238	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,366	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,226	26,122	0	0	11,607	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,815	0	0	1,969	0	90.00
90.01	09001	SENIOR CARE	4,397	0	0	0	0	90.01
91.00	09100	EMERGENCY	138,016	139,751	0	61,772	62,094	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	66,092	0	49,419	12,621	0	95.00
101.00	10100	HOME HEALTH AGENCY	6,821	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,128,526	1,970,938	49,419	347,060	848,478	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,365	0	0	7,716	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	140,965	0	6,624	62,633	192.00
194.00	07950	MARKETING	0	4,560	0	0	2,026	194.00
194.01	07951	PHYSICIAN BILLING	0	10,653	0	0	4,733	194.01
194.02	07952	MOB	0	0	0	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)	1,128,526	2,144,481	49,419	353,684	925,586	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/22/2017 10:32 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER A&G						5.01
5.02	00560	ADMITTING						5.02
5.03	00590	PATIENT ACCOUNTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	AMB PLANT OPS						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	732,167					10.00
11.00	01100	CAFETERIA	0	517,181				11.00
13.00	01300	NURSING ADMINISTRATION	0	13,519	919,728			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,472	0	402,225		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	32,752	0	2,507	1,183,351	16.00
17.00	01700	SOCIAL SERVICE	0	7,425	0	241	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	692,212	89,094	381,675	4,956	115,846	30.00
31.00	03100	INTENSIVE CARE UNIT	39,955	12,701	51,592	1,568	13,254	31.00
43.00	04300	NURSERY	0	9,948	28,304	7	15,305	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	29,477	123,608	20,899	84,607	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	5,964	0	242	12,546	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	45,425	0	2,864	339,055	54.00
60.00	06000	LABORATORY	0	31,377	0	2,484	187,327	60.00
65.00	06500	RESPIRATORY THERAPY	0	12,073	0	625	13,059	65.00
66.00	06600	PHYSICAL THERAPY	0	8,805	0	563	14,923	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	8	2,258	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	261	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,461	17,229	739	33,829	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	324,777	56,727	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	28,776	3,530	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,616	0	509	63,148	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	742	2,844	19	1,903	90.00
90.01	09001	SENIOR CARE	0	4,602	19,026	177	4,610	90.01
91.00	09100	EMERGENCY	0	48,916	202,380	3,253	144,712	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	7,011	69,299	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	93,070	0	7,152	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	732,167	385,369	919,728	402,225	1,183,351	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	107,247	0	0	0	192.00
194.00	07950	MARKETING	0	2,024	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	22,541	0	0	0	194.01
194.02	07952	MOB	0	0	0	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)	732,167	517,181	919,728	402,225	1,183,351	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/22/2017 10:32 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER A&G						5.01
5.02	00560	ADMITTING						5.02
5.03	00590	PATIENT ACCOUNTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	AMB PLANT OPS						7.01
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	345,325					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	326,480	6,996,323	0	6,996,323		30.00
31.00	03100	INTENSIVE CARE UNIT	18,845	999,061	0	999,061		31.00
43.00	04300	NURSERY	0	359,442	0	359,442		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,942,588	0	2,942,588		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	78,022	0	78,022		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,942,526	0	3,942,526		54.00
60.00	06000	LABORATORY	0	3,173,592	0	3,173,592		60.00
65.00	06500	RESPIRATORY THERAPY	0	628,837	0	628,837		65.00
66.00	06600	PHYSICAL THERAPY	0	590,368	0	590,368		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	54,546	0	54,546		67.00
68.00	06800	SPEECH PATHOLOGY	0	642	0	642		68.00
69.00	06900	ELECTROCARDIOLOGY	0	629,017	0	629,017		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,772,237	0	2,772,237		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	221,029	0	221,029		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,840,422	0	2,840,422		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	88,531	0	88,531		90.00
90.01	09001	SENIOR CARE	0	368,258	0	368,258		90.01
91.00	09100	EMERGENCY	0	3,005,089	0	3,005,089		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,643,478	0	3,643,478		95.00
101.00	10100	HOME HEALTH AGENCY	0	1,120,530	0	1,120,530		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	345,325	34,454,538	0	34,454,538		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	44,170	0	44,170		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,628,600	0	11,628,600		192.00
194.00	07950	MARKETING	0	438,267	0	438,267		194.00
194.01	07951	PHYSICIAN BILLING	0	779,307	0	779,307		194.01
194.02	07952	MOB	0	832,692	0	832,692		194.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	345,325	48,177,574	0	48,177,574		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/22/2017 10:32 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,246	0	0	1,012	4.00
5.01	00540	OTHER A&G	0	322,958	5,200	0	100,694	5.01
5.02	00560	ADMITTING	0	0	0	0	0	5.02
5.03	00590	PATIENT ACCOUNTING	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	0	254,640	0	0	79,394	7.00
7.01	00701	AMB PLANT OPS	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,868	0	0	4,636	8.00
9.00	00900	HOUSEKEEPING	0	31,846	0	0	9,929	9.00
10.00	01000	DIETARY	0	92,666	0	0	28,892	10.00
11.00	01100	CAFETERIA	0	46,292	0	0	14,433	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,791	0	0	2,429	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	51,697	0	0	16,119	16.00
17.00	01700	SOCIAL SERVICE	0	3,116	0	0	972	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	376,619	0	0	117,425	30.00
31.00	03100	INTENSIVE CARE UNIT	0	47,023	0	0	14,661	31.00
43.00	04300	NURSERY	0	9,739	0	0	3,036	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	287,654	0	0	89,687	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	150,709	0	0	46,989	54.00
60.00	06000	LABORATORY	0	79,210	0	0	24,697	60.00
65.00	06500	RESPIRATORY THERAPY	0	17,238	0	0	5,375	65.00
66.00	06600	PHYSICAL THERAPY	0	58,320	0	0	18,183	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	29,606	0	0	9,231	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	70,704	0	0	22,045	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	19,900	0	0	6,205	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	42,790	0	0	90.00
90.01	09001	SENIOR CARE	0	0	31,038	0	0	90.01
91.00	09100	EMERGENCY	0	106,462	42,790	0	33,194	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	63,733	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	30,322	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,082,304	152,140	63,733	649,238	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,229	0	0	4,125	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	107,388	0	0	33,482	192.00
194.00	07950	MARKETING	0	3,474	0	0	1,083	194.00
194.01	07951	PHYSICIAN BILLING	0	8,116	0	0	2,530	194.01
194.02	07952	MOB	0	0	757,016	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	2,214,511	909,156	63,733	690,458	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/22/2017 10:32 am

		Cost Center Description	CAPITAL RELATED COSTS AMB EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	OTHER A&G	ADMITTING	
			2.01	2A	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,258	4,258			4.00
5.01	00540	OTHER A&G	0	428,852	239	429,091		5.01
5.02	00560	ADMITTING	0	0	74	5,324	5,398	5.02
5.03	00590	PATIENT ACCOUNTING	0	0	72	10,051	0	5.03
7.00	00700	OPERATION OF PLANT	0	334,034	41	19,100	0	7.00
7.01	00701	AMB PLANT OPS	0	0	0	440	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,504	4	2,976	0	8.00
9.00	00900	HOUSEKEEPING	0	41,775	81	7,565	0	9.00
10.00	01000	DIETARY	0	121,558	31	4,701	0	10.00
11.00	01100	CAFETERIA	0	60,725	39	3,825	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,220	103	7,940	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	41	3,454	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	67,816	120	9,353	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,088	43	2,955	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	494,044	470	38,857	530	30.00
31.00	03100	INTENSIVE CARE UNIT	0	61,684	85	6,704	61	31.00
43.00	04300	NURSERY	0	12,775	33	2,361	70	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	377,341	166	17,774	387	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	40	365	57	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	197,698	220	24,403	1,537	54.00
60.00	06000	LABORATORY	0	103,907	134	22,524	856	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,613	0	4,905	60	65.00
66.00	06600	PHYSICAL THERAPY	0	76,503	45	3,836	68	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	436	10	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1	68.00
69.00	06900	ELECTROCARDIOLOGY	0	38,837	47	4,028	155	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	92,749	0	19,362	259	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,635	16	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	26,105	63	23,507	289	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	42,790	4	697	9	90.00
90.01	09001	SENIOR CARE	0	31,038	22	2,967	21	90.01
91.00	09100	EMERGENCY	0	182,446	244	18,981	662	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	134,866	198,599	335	30,318	317	95.00
101.00	10100	HOME HEALTH AGENCY	0	30,322	107	8,995	33	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	134,866	3,082,281	2,903	310,339	5,398	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,354	0	170	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	140,870	1,261	100,736	0	192.00
194.00	07950	MARKETING	0	4,557	11	3,827	0	194.00
194.01	07951	PHYSICIAN BILLING	0	10,646	83	6,603	0	194.01
194.02	07952	MOB	0	757,016	0	7,416	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)	134,866	4,012,724	4,258	429,091	5,398	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/22/2017 10:32 am

		Cost Center Description	PATIENT ACCOUNTING	OPERATION OF PLANT	AMB PLANT OPS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.03	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER A&G						5.01
5.02	00560	ADMITTING						5.02
5.03	00590	PATIENT ACCOUNTING	10,123					5.03
7.00	00700	OPERATION OF PLANT	0	353,175				7.00
7.01	00701	AMB PLANT OPS	0	0	440			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,214	0	25,698		8.00
9.00	00900	HOUSEKEEPING	0	6,885	0	2,502	58,808	9.00
10.00	01000	DIETARY	0	20,033	0	2,081	3,434	10.00
11.00	01100	CAFETERIA	0	10,008	0	0	1,715	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,684	0	0	289	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,176	0	0	1,916	16.00
17.00	01700	SOCIAL SERVICE	0	674	0	0	115	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	995	81,418	0	10,199	13,957	30.00
31.00	03100	INTENSIVE CARE UNIT	114	10,166	0	0	1,743	31.00
43.00	04300	NURSERY	131	2,105	0	0	361	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	726	62,187	0	1,426	10,660	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	108	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,876	32,581	0	2,540	5,585	54.00
60.00	06000	LABORATORY	1,608	17,124	0	0	2,935	60.00
65.00	06500	RESPIRATORY THERAPY	112	3,727	0	42	639	65.00
66.00	06600	PHYSICAL THERAPY	128	12,608	0	223	2,161	66.00
67.00	06700	OCCUPATIONAL THERAPY	19	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	290	6,400	0	656	1,097	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	487	15,285	0	0	2,620	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	30	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	542	4,302	0	0	737	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	16	0	0	143	0	90.00
90.01	09001	SENIOR CARE	40	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,243	23,016	0	4,488	3,945	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	595	0	440	917	0	95.00
101.00	10100	HOME HEALTH AGENCY	61	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,123	324,593	440	25,217	53,909	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,860	0	0	490	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	23,216	0	481	3,979	192.00
194.00	07950	MARKETING	0	751	0	0	129	194.00
194.01	07951	PHYSICIAN BILLING	0	1,755	0	0	301	194.01
194.02	07952	MOB	0	0	0	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)	10,123	353,175	440	25,698	58,808	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/22/2017 10:32 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER A&G						5.01
5.02	00560	ADMITTING						5.02
5.03	00590	PATIENT ACCOUNTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	AMB PLANT OPS						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	151,838					10.00
11.00	01100	CAFETERIA	0	76,312				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,995	22,231			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,135	0	5,630		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,833	0	35	95,249	16.00
17.00	01700	SOCIAL SERVICE	0	1,096	0	3	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	143,552	13,146	9,225	69	9,327	30.00
31.00	03100	INTENSIVE CARE UNIT	8,286	1,874	1,247	22	1,067	31.00
43.00	04300	NURSERY	0	1,468	684	0	1,232	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,349	2,988	292	6,812	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	880	0	3	1,010	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,703	0	40	27,276	54.00
60.00	06000	LABORATORY	0	4,630	0	35	15,081	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,781	0	9	1,051	65.00
66.00	06600	PHYSICAL THERAPY	0	1,299	0	8	1,201	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	182	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	21	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,543	416	10	2,724	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,548	4,567	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	403	284	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,124	0	7	5,084	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	109	69	0	153	90.00
90.01	09001	SENIOR CARE	0	679	460	2	371	90.01
91.00	09100	EMERGENCY	0	7,218	4,892	46	11,651	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	98	5,579	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	2,250	0	576	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	151,838	56,862	22,231	5,630	95,249	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	15,825	0	0	0	192.00
194.00	07950	MARKETING	0	299	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	3,326	0	0	0	194.01
194.02	07952	MOB	0	0	0	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)	151,838	76,312	22,231	5,630	95,249	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/22/2017 10:32 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER A&G						5.01
5.02	00560	ADMITTING						5.02
5.03	00590	PATIENT ACCOUNTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	AMB PLANT OPS						7.01
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	8,974					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,484	824,273	0	824,273		30.00
31.00	03100	INTENSIVE CARE UNIT	490	93,543	0	93,543		31.00
43.00	04300	NURSERY	0	21,220	0	21,220		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	485,108	0	485,108		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	2,463	0	2,463		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	301,459	0	301,459		54.00
60.00	06000	LABORATORY	0	168,834	0	168,834		60.00
65.00	06500	RESPIRATORY THERAPY	0	34,939	0	34,939		65.00
66.00	06600	PHYSICAL THERAPY	0	98,080	0	98,080		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	647	0	647		67.00
68.00	06800	SPEECH PATHOLOGY	0	24	0	24		68.00
69.00	06900	ELECTROCARDIOLOGY	0	56,203	0	56,203		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	139,877	0	139,877		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,368	0	2,368		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	61,760	0	61,760		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	43,990	0	43,990		90.00
90.01	09001	SENIOR CARE	0	35,600	0	35,600		90.01
91.00	09100	EMERGENCY	0	258,832	0	258,832		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	237,198	0	237,198		95.00
101.00	10100	HOME HEALTH AGENCY	0	42,344	0	42,344		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,974	2,908,762	0	2,908,762		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,874	0	20,874		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	286,368	0	286,368		192.00
194.00	07950	MARKETING	0	9,574	0	9,574		194.00
194.01	07951	PHYSICIAN BILLING	0	22,714	0	22,714		194.01
194.02	07952	MOB	0	764,432	0	764,432		194.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	8,974	4,012,724	0	4,012,724		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/22/2017 10:32 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	AMB EQUIP (SQUARE FEET)	
			1.00	1.01	1.02	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	136,433					1.00
1.01	00101	MOB	0	34,271				1.01
1.02	00102	AMB DEPR	0	0	11,032			1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				136,433		2.00
2.01	00201	AMB EQUIP				0	11,032	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	200	0	0	200	0	4.00
5.01	00540	OTHER A&G	19,897	196	0	19,897	0	5.01
5.02	00560	ADMITTING	0	0	0	0	0	5.02
5.03	00590	PATIENT ACCOUNTING	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	15,688	0	0	15,688	0	7.00
7.01	00701	AMB PLANT OPS	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	916	0	0	916	0	8.00
9.00	00900	HOUSEKEEPING	1,962	0	0	1,962	0	9.00
10.00	01000	DIETARY	5,709	0	0	5,709	0	10.00
11.00	01100	CAFETERIA	2,852	0	0	2,852	0	11.00
13.00	01300	NURSING ADMINISTRATION	480	0	0	480	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,185	0	0	3,185	0	16.00
17.00	01700	SOCIAL SERVICE	192	0	0	192	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,203	0	0	23,203	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,897	0	0	2,897	0	31.00
43.00	04300	NURSERY	600	0	0	600	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,722	0	0	17,722	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,285	0	0	9,285	0	54.00
60.00	06000	LABORATORY	4,880	0	0	4,880	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,062	0	0	1,062	0	65.00
66.00	06600	PHYSICAL THERAPY	3,593	0	0	3,593	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,824	0	0	1,824	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,356	0	0	4,356	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	1,226	0	0	1,226	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,613	0	0	0	90.00
90.01	09001	SENIOR CARE	0	1,170	0	0	0	90.01
91.00	09100	EMERGENCY	6,559	1,613	0	6,559	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	11,032	0	11,032	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,143	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	128,288	5,735	11,032	128,288	11,032	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	0	815	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,616	0	0	6,616	0	192.00
194.00	07950	MARKETING	214	0	0	214	0	194.00
194.01	07951	PHYSICIAN BILLING	500	0	0	500	0	194.01
194.02	07952	MOB	0	28,536	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)	2,214,511	909,156	63,733	690,458	134,866	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.231491	26.528435	5.777103	5.060784	12.224982	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/22/2017 10:32 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER A&G (ACCUM COST)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	
			4.00	5A.01	5.01	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	24,059,210					4.00
5.01	00540	OTHER A&G	1,348,687	-4,378,441	43,799,133			5.01
5.02	00560	ADMITTING	416,650	0	543,473	131,950,816		5.02
5.03	00590	PATIENT ACCOUNTING	406,001	0	1,025,964	0	131,950,816	5.03
7.00	00700	OPERATION OF PLANT	231,891	0	1,949,588	0	0	7.00
7.01	00701	AMB PLANT OPS	0	0	44,928	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	24,768	0	303,798	0	0	8.00
9.00	00900	HOUSEKEEPING	454,807	0	772,153	0	0	9.00
10.00	01000	DIETARY	173,478	0	479,868	0	0	10.00
11.00	01100	CAFETERIA	221,599	0	390,388	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	582,302	0	810,423	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	232,284	0	352,514	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	680,504	0	954,646	0	0	16.00
17.00	01700	SOCIAL SERVICE	240,932	0	301,600	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,656,278	0	3,966,175	12,917,681	12,917,681	30.00
31.00	03100	INTENSIVE CARE UNIT	478,357	0	684,256	1,477,908	1,477,908	31.00
43.00	04300	NURSERY	185,492	0	240,995	1,706,644	1,706,644	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	936,601	0	1,814,206	9,434,287	9,434,287	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	228,405	0	37,244	1,399,000	1,399,000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,241,792	0	2,490,872	37,805,300	37,805,300	54.00
60.00	06000	LABORATORY	755,289	0	2,299,112	20,888,404	20,888,404	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	500,712	1,456,194	1,456,194	65.00
66.00	06600	PHYSICAL THERAPY	252,821	0	391,532	1,664,011	1,664,011	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	44,533	251,791	251,791	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	29,121	29,121	68.00
69.00	06900	ELECTROCARDIOLOGY	266,509	0	411,146	3,772,226	3,772,226	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,976,357	6,325,525	6,325,525	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	166,891	393,603	393,603	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	353,541	0	2,399,434	7,041,474	7,041,474	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	20,149	0	71,164	212,210	212,210	90.00
90.01	09001	SENIOR CARE	127,047	0	302,843	514,076	514,076	90.01
91.00	09100	EMERGENCY	1,381,131	0	1,937,421	16,136,503	16,136,503	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,894,578	0	3,094,669	7,727,360	7,727,360	95.00
101.00	10100	HOME HEALTH AGENCY	604,998	0	918,096	797,498	797,498	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,396,891	-4,378,441	31,677,001	131,950,816	131,950,816	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	17,354	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,131,119	0	10,283,150	0	0	192.00
194.00	07950	MARKETING	62,516	0	390,609	0	0	194.00
194.01	07951	PHYSICIAN BILLING	468,684	0	674,003	0	0	194.01
194.02	07952	MOB	0	0	757,016	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)	5,510,573		4,378,441	597,802	1,128,526	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.229042		0.099966	0.004530	0.008553	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,258		429,091	5,398	10,123	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000177		0.009797	0.000041	0.000077	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/22/2017 10:32 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	AMB PLANT OPS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER A&G						5.01
5.02	00560	ADMITTING						5.02
5.03	00590	PATIENT ACCOUNTING						5.03
7.00	00700	OPERATION OF PLANT	100,648					7.00
7.01	00701	AMB PLANT OPS	0	11,032				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	916	0	305,004			8.00
9.00	00900	HOUSEKEEPING	1,962	0	29,700	97,770		9.00
10.00	01000	DIETARY	5,709	0	24,700	5,709	4,911	10.00
11.00	01100	CAFETERIA	2,852	0	0	2,852	0	11.00
13.00	01300	NURSING ADMINISTRATION	480	0	0	480	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,185	0	0	3,185	0	16.00
17.00	01700	SOCIAL SERVICE	192	0	0	192	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,203	0	121,040	23,203	4,643	30.00
31.00	03100	INTENSIVE CARE UNIT	2,897	0	0	2,897	268	31.00
43.00	04300	NURSERY	600	0	0	600	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,722	0	16,930	17,722	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,285	0	30,141	9,285	0	54.00
60.00	06000	LABORATORY	4,880	0	0	4,880	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,062	0	500	1,062	0	65.00
66.00	06600	PHYSICAL THERAPY	3,593	0	2,643	3,593	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,824	0	7,786	1,824	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,356	0	0	4,356	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	1,226	0	0	1,226	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	1,698	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	6,559	0	53,270	6,559	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	11,032	10,884	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	92,503	11,032	299,292	89,625	4,911	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	0	815	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,616	0	5,712	6,616	0	192.00
194.00	07950	MARKETING	214	0	0	214	0	194.00
194.01	07951	PHYSICIAN BILLING	500	0	0	500	0	194.01
194.02	07952	MOB	0	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)	2,144,481	49,419	353,684	925,586	732,167	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.306742	4.479605	1.159604	9.466974	149.087151	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	353,175	440	25,698	58,808	151,838	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.509012	0.039884	0.084255	0.601493	30.917939	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/22/2017 10:32 am

		Cost Center Description	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	
			11.00	13.00	14.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER A&G						5.01
5.02	00560	ADMITTING						5.02
5.03	00590	PATIENT ACCOUNTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	AMB PLANT OPS						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	474,932					11.00
13.00	01300	NURSING ADMINISTRATION	12,415	230,877				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,290	0	2,332,765			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,076	0	14,539	131,950,816		16.00
17.00	01700	SOCIAL SERVICE	6,818	0	1,396	0	4,911	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	81,816	95,811	28,744	12,917,681	4,643	30.00
31.00	03100	INTENSIVE CARE UNIT	11,663	12,951	9,091	1,477,908	268	31.00
43.00	04300	NURSERY	9,135	7,105	40	1,706,644	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,069	31,029	121,205	9,434,287	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	5,477	0	1,402	1,399,000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,714	0	16,608	37,805,300	0	54.00
60.00	06000	LABORATORY	28,814	0	14,406	20,888,404	0	60.00
65.00	06500	RESPIRATORY THERAPY	11,087	0	3,622	1,456,194	0	65.00
66.00	06600	PHYSICAL THERAPY	8,086	0	3,266	1,664,011	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	48	251,791	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	29,121	0	68.00
69.00	06900	ELECTROCARDIOLOGY	9,606	4,325	4,284	3,772,226	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,883,608	6,325,525	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	166,891	393,603	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,994	0	2,951	7,041,474	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	681	714	110	212,210	0	90.00
90.01	09001	SENIOR CARE	4,226	4,776	1,026	514,076	0	90.01
91.00	09100	EMERGENCY	44,920	50,803	18,866	16,136,503	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	40,662	7,727,360	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	23,363	0	797,498	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	353,887	230,877	2,332,765	131,950,816	4,911	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	98,486	0	0	0	0	192.00
194.00	07950	MARKETING	1,859	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	20,700	0	0	0	0	194.01
194.02	07952	MOB	0	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)	517,181	919,728	402,225	1,183,351	345,325	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.088958	3.983628	0.172424	0.008968	70.316636	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	76,312	22,231	5,630	95,249	8,974	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.160680	0.096289	0.002413	0.000722	1.827326	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/22/2017 10:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,996,323		6,996,323	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	999,061		999,061	0	0	31.00
43.00	04300	NURSERY	359,442		359,442	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,942,588		2,942,588	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	78,022		78,022	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,942,526		3,942,526	0	0	54.00
60.00	06000	LABORATORY	3,173,592		3,173,592	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	628,837	0	628,837	0	0	65.00
66.00	06600	PHYSICAL THERAPY	590,368	0	590,368	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	54,546	0	54,546	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	642	0	642	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	629,017		629,017	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,772,237		2,772,237	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	221,029		221,029	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,840,422		2,840,422	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	88,531		88,531	0	0	90.00
90.01	09001	SENIOR CARE	368,258		368,258	0	0	90.01
91.00	09100	EMERGENCY	3,005,089		3,005,089	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,685,690		1,685,690		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,643,478		3,643,478	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	1,120,530		1,120,530		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	36,140,228	0	36,140,228	0	0	200.00
201.00		Less Observation Beds	1,685,690		1,685,690		0	201.00
202.00		Total (see instructions)	34,454,538	0	34,454,538	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/22/2017 10:32 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,407,387		11,407,387			30.00
31.00	03100	INTENSIVE CARE UNIT	1,477,908		1,477,908			31.00
43.00	04300	NURSERY	1,706,644		1,706,644			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,349,680	7,084,607	9,434,287	0.311904	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	271,603	1,127,397	1,399,000	0.055770	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,442,573	35,362,727	37,805,300	0.104285	0.000000	54.00
60.00	06000	LABORATORY	3,407,833	17,480,571	20,888,404	0.151931	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,067,799	388,395	1,456,194	0.431836	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	472,004	1,192,007	1,664,011	0.354786	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	75,368	176,423	251,791	0.216632	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,344	27,777	29,121	0.022046	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	246,575	3,525,651	3,772,226	0.166750	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,707,103	3,618,422	6,325,525	0.438262	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	54,396	339,207	393,603	0.561553	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,436,656	4,604,818	7,041,474	0.403385	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	212,210	212,210	0.417186	0.000000	90.00
90.01	09001	SENIOR CARE	0	514,076	514,076	0.716349	0.000000	90.01
91.00	09100	EMERGENCY	93,135	16,043,368	16,136,503	0.186229	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,694	1,507,600	1,510,294	1.116134	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	7,727,360	7,727,360	0.471504	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	797,498	797,498			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	30,220,702	101,730,114	131,950,816			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	30,220,702	101,730,114	131,950,816			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/22/2017 10:32 am

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		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
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
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			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SENIOR CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/22/2017 10:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,996,323		6,996,323	0	6,996,323	30.00
31.00	03100	INTENSIVE CARE UNIT	999,061		999,061	0	999,061	31.00
43.00	04300	NURSERY	359,442		359,442	0	359,442	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,942,588		2,942,588	0	2,942,588	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	78,022		78,022	0	78,022	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,942,526		3,942,526	0	3,942,526	54.00
60.00	06000	LABORATORY	3,173,592		3,173,592	0	3,173,592	60.00
65.00	06500	RESPIRATORY THERAPY	628,837	0	628,837	0	628,837	65.00
66.00	06600	PHYSICAL THERAPY	590,368	0	590,368	0	590,368	66.00
67.00	06700	OCCUPATIONAL THERAPY	54,546	0	54,546	0	54,546	67.00
68.00	06800	SPEECH PATHOLOGY	642	0	642	0	642	68.00
69.00	06900	ELECTROCARDIOLOGY	629,017		629,017	0	629,017	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,772,237		2,772,237	0	2,772,237	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	221,029		221,029	0	221,029	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,840,422		2,840,422	0	2,840,422	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	88,531		88,531	0	88,531	90.00
90.01	09001	SENIOR CARE	368,258		368,258	0	368,258	90.01
91.00	09100	EMERGENCY	3,005,089		3,005,089	0	3,005,089	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,685,690		1,685,690		1,685,690	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,643,478		3,643,478	0	3,643,478	95.00
101.00	10100	HOME HEALTH AGENCY	1,120,530		1,120,530		1,120,530	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	36,140,228	0	36,140,228	0	36,140,228	200.00
201.00		Less Observation Beds	1,685,690		1,685,690		1,685,690	201.00
202.00		Total (see instructions)	34,454,538	0	34,454,538	0	34,454,538	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/22/2017 10:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,407,387		11,407,387			30.00
31.00	03100	INTENSIVE CARE UNIT	1,477,908		1,477,908			31.00
43.00	04300	NURSERY	1,706,644		1,706,644			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,349,680	7,084,607	9,434,287	0.311904	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	271,603	1,127,397	1,399,000	0.055770	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,442,573	35,362,727	37,805,300	0.104285	0.000000	54.00
60.00	06000	LABORATORY	3,407,833	17,480,571	20,888,404	0.151931	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,067,799	388,395	1,456,194	0.431836	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	472,004	1,192,007	1,664,011	0.354786	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	75,368	176,423	251,791	0.216632	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,344	27,777	29,121	0.022046	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	246,575	3,525,651	3,772,226	0.166750	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,707,103	3,618,422	6,325,525	0.438262	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	54,396	339,207	393,603	0.561553	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,436,656	4,604,818	7,041,474	0.403385	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	212,210	212,210	0.417186	0.000000	90.00
90.01	09001	SENIOR CARE	0	514,076	514,076	0.716349	0.000000	90.01
91.00	09100	EMERGENCY	93,135	16,043,368	16,136,503	0.186229	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,694	1,507,600	1,510,294	1.116134	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	7,727,360	7,727,360	0.471504	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	797,498	797,498			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	30,220,702	101,730,114	131,950,816			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	30,220,702	101,730,114	131,950,816			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/22/2017 10:32 am

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
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
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			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SENIOR CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/22/2017 10:32 am

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	485,108	9,434,287	0.051420	373,298	19,195	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,463	1,399,000	0.001761	51,000	90	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	301,459	37,805,300	0.007974	1,295,695	10,332	54.00
60.00	06000	LABORATORY	168,834	20,888,404	0.008083	1,518,015	12,270	60.00
65.00	06500	RESPIRATORY THERAPY	34,939	1,456,194	0.023993	617,661	14,820	65.00
66.00	06600	PHYSICAL THERAPY	98,080	1,664,011	0.058942	365,064	21,518	66.00
67.00	06700	OCCUPATIONAL THERAPY	647	251,791	0.002570	55,423	142	67.00
68.00	06800	SPEECH PATHOLOGY	24	29,121	0.000824	672	1	68.00
69.00	06900	ELECTROCARDIOLOGY	56,203	3,772,226	0.014899	131,033	1,952	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	139,877	6,325,525	0.022113	1,363,384	30,149	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,368	393,603	0.006016	32,108	193	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,760	7,041,474	0.008771	1,187,560	10,416	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	43,990	212,210	0.207295	0	0	90.00
90.01	09001	SENIOR CARE	35,600	514,076	0.069250	0	0	90.01
91.00	09100	EMERGENCY	258,832	16,136,503	0.016040	7,656	123	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	198,600	1,510,294	0.131498	2,694	354	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,888,784	108,834,019		7,001,263	121,555	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/22/2017 10:32 am

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	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/22/2017 10:32 am

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	9,434,287	0.000000	0.000000	373,298	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,399,000	0.000000	0.000000	51,000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,805,300	0.000000	0.000000	1,295,695	54.00
60.00	06000	LABORATORY	0	20,888,404	0.000000	0.000000	1,518,015	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,456,194	0.000000	0.000000	617,661	65.00
66.00	06600	PHYSICAL THERAPY	0	1,664,011	0.000000	0.000000	365,064	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	251,791	0.000000	0.000000	55,423	67.00
68.00	06800	SPEECH PATHOLOGY	0	29,121	0.000000	0.000000	672	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,772,226	0.000000	0.000000	131,033	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,325,525	0.000000	0.000000	1,363,384	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	393,603	0.000000	0.000000	32,108	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,041,474	0.000000	0.000000	1,187,560	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	212,210	0.000000	0.000000	0	90.00
90.01	09001	SENIOR CARE	0	514,076	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	16,136,503	0.000000	0.000000	7,656	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,510,294	0.000000	0.000000	2,694	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	108,834,019			7,001,263	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/22/2017 10:32 am

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	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
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					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	SENIOR CARE	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/22/2017 10:32 am

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	0.311904	0	1,949,431	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.055770	0	219,750	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104285	0	12,221,719	0	0	54.00
60.00	06000	LABORATORY	0.151931	0	5,037,399	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.431836	0	210,870	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.354786	0	404,219	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.216632	0	45,639	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.022046	0	6,636	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.166750	0	1,392,976	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.438262	0	861,528	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.561553	0	104,555	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.403385	0	3,684,420	660	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.417186	0	25,246	0	0	90.00
90.01	09001	SENIOR CARE	0.716349	0	496,472	0	0	90.01
91.00	09100	EMERGENCY	0.186229	0	3,028,040	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.116134	0	624,898	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.471504		0			95.00
200.00		Subtotal (see instructions)		0	30,313,798	660	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	30,313,798	660	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/22/2017 10:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	608,035	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	12,255	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,274,542	0	54.00
60.00	06000	LABORATORY	765,337	0	60.00
65.00	06500	RESPIRATORY THERAPY	91,061	0	65.00
66.00	06600	PHYSICAL THERAPY	143,411	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,887	0	67.00
68.00	06800	SPEECH PATHOLOGY	146	0	68.00
69.00	06900	ELECTROCARDIOLOGY	232,279	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	377,575	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	58,713	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,486,240	266	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	10,532	0	90.00
90.01	09001	SENIOR CARE	355,647	0	90.01
91.00	09100	EMERGENCY	563,909	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	697,470	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	6,687,039	266	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	6,687,039	266	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/22/2017 10:32 am

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	0.311904	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.055770	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104285	0	0	0	0	54.00
60.00	06000	LABORATORY	0.151931	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.431836	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.354786	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.216632	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.022046	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.166750	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.438262	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.561553	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.403385	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.417186	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.716349	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.186229	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.116134	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.471504		0			95.00
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: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 5/22/2017 10:32 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
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
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
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			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	SENIOR CARE	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
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: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/22/2017 10:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.311904	0	0	1,399,910	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.055770	0	0	907,647	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104285	0	0	6,946,610	0	54.00
60.00	06000	LABORATORY	0.151931	0	0	3,601,861	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.431836	0	0	82,554	0	65.00
66.00	06600	PHYSICAL THERAPY	0.354786	0	0	232,155	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.216632	0	0	42,543	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.022046	0	0	7,672	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.166750	0	0	505,132	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.438262	0	0	908,957	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.561553	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.403385	0	0	819,096	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.417186	0	0	16,940	0	90.00
90.01	09001	SENIOR CARE	0.716349	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.186229	0	0	5,005,220	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.116134	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.471504	0	0			95.00
200.00		Subtotal (see instructions)		0	0	20,476,297	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	20,476,297	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/22/2017 10:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	436,638		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	50,619		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	724,427		54.00
60.00	06000	LABORATORY	0	547,234		60.00
65.00	06500	RESPIRATORY THERAPY	0	35,650		65.00
66.00	06600	PHYSICAL THERAPY	0	82,365		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,216		67.00
68.00	06800	SPEECH PATHOLOGY	0	169		68.00
69.00	06900	ELECTROCARDIOLOGY	0	84,231		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	398,361		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	330,411		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	7,067		90.00
90.01	09001	SENIOR CARE	0	0		90.01
91.00	09100	EMERGENCY	0	932,117		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	3,638,505		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	3,638,505		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/22/2017 10:32 am

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)	5,657	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,657	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)	4,294	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,023	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,996,323	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,996,323	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,996,323	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,236.75	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,501,945	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,501,945	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/22/2017 10:32 am

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	999,061	543	1,839.89	330	607,164	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)	2,014,178	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,123,287	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,363	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,236.75	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,685,690	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/22/2017 10:32 am

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	824,273	6,996,323	0.117815	1,685,690	198,600	90.00
91.00	Nursing School cost	0	6,996,323	0.000000	1,685,690	0	91.00
92.00	Allied health cost	0	6,996,323	0.000000	1,685,690	0	92.00
93.00	All other Medical Education	0	6,996,323	0.000000	1,685,690	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/22/2017 10:32 am

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)	5,657	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,657	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)	4,294	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	679	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)	1,015	15.00
16.00	Nursery days (title V or XIX only)	574	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,996,323	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,996,323	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,996,323	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,236.75	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	839,753	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)	839,753	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/22/2017 10:32 am

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)	359,442	1,015	354.13	574	203,271	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	999,061	543	1,839.89	61	112,233	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)	932,922	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,088,179	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,363	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,236.75	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,685,690	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/22/2017 10:32 am

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	824,273	6,996,323	0.117815	1,685,690	198,600	90.00
91.00	Nursing School cost	0	6,996,323	0.000000	1,685,690	0	91.00
92.00	Allied health cost	0	6,996,323	0.000000	1,685,690	0	92.00
93.00	All other Medical Education	0	6,996,323	0.000000	1,685,690	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/22/2017 10:32 am

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		2,849,106		30.00
31.00	03100	INTENSIVE CARE UNIT		827,185		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.311904	373,298	116,433	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.055770	51,000	2,844	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104285	1,295,695	135,122	54.00
60.00	06000	LABORATORY	0.151931	1,518,015	230,634	60.00
65.00	06500	RESPIRATORY THERAPY	0.431836	617,661	266,728	65.00
66.00	06600	PHYSICAL THERAPY	0.354786	365,064	129,520	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.216632	55,423	12,006	67.00
68.00	06800	SPEECH PATHOLOGY	0.022046	672	15	68.00
69.00	06900	ELECTROCARDIOLOGY	0.166750	131,033	21,850	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.438262	1,363,384	597,519	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.561553	32,108	18,030	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.403385	1,187,560	479,044	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.417186	0	0	90.00
90.01	09001	SENIOR CARE	0.716349	0	0	90.01
91.00	09100	EMERGENCY	0.186229	7,656	1,426	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.116134	2,694	3,007	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		7,001,263	2,014,178	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)		7,001,263		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/22/2017 10:32 am

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	0.311904	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.055770	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104285	0	0	54.00
60.00	06000	LABORATORY	0.151931	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.431836	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.354786	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.216632	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.022046	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.166750	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.438262	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.561553	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.403385	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.417186	0	0	90.00
90.01	09001	SENIOR CARE	0.716349	0	0	90.01
91.00	09100	EMERGENCY	0.186229	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.116134	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	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)		0		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/22/2017 10:32 am

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		3,370,561		30.00
31.00	03100	INTENSIVE CARE UNIT		209,206		31.00
43.00	04300	NURSERY		652,608		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.311904	911,261	284,226	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.055770	126,000	7,027	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104285	415,266	43,306	54.00
60.00	06000	LABORATORY	0.151931	857,300	130,250	60.00
65.00	06500	RESPIRATORY THERAPY	0.431836	235,154	101,548	65.00
66.00	06600	PHYSICAL THERAPY	0.354786	18,874	6,696	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.216632	4,521	979	67.00
68.00	06800	SPEECH PATHOLOGY	0.022046	336	7	68.00
69.00	06900	ELECTROCARDIOLOGY	0.166750	41,236	6,876	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.438262	417,254	182,867	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.561553	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.403385	406,919	164,145	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.417186	0	0	90.00
90.01	09001	SENIOR CARE	0.716349	0	0	90.01
91.00	09100	EMERGENCY	0.186229	26,820	4,995	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.116134	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		3,460,941	932,922	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)		3,460,941		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/22/2017 10:32 am

Title XIX | 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		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.311904	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.055770	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104285	0	0	54.00
60.00	06000	LABORATORY	0.151931	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.431836	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.354786	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.216632	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.022046	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.166750	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.438262	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.561553	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.403385	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.417186	0	0	90.00
90.01	09001	SENIOR CARE	0.716349	0	0	90.01
91.00	09100	EMERGENCY	0.186229	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.116134	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1331	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/22/2017 10:32 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,687,305	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)	6,687,305	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)	6,754,178	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)	57,270	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	5,089,989	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,606,919	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,606,919	30.00
31.00	Primary payer payments	4,902	31.00
32.00	Subtotal (line 30 minus line 31)	1,602,017	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)	968,490	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	629,519	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	727,536	36.00
37.00	Subtotal (see instructions)	2,231,536	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,231,536	40.00
40.01	Sequestration adjustment (see instructions)	44,631	40.01
41.00	Interim payments	2,555,248	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-368,343	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	31,439	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 5/22/2017 10:32 am

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		4,383,410		2,454,048	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	07/14/2016	101,200	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		101,200	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)		4,383,410		2,555,248	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		139,478		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		368,343	6.02
7.00	Total Medicare program liability (see instructions)		4,522,888		2,186,905	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: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/22/2017 10:32 am

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		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		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: 15-1331	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/22/2017 10:32 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,909	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,353	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	161	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4,837	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	131,950,816	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,496,577	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: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-2 | Date/Time Prepared: 5/22/2017 10:32 am

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)	0	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)	0	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	0	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)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	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)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	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)	0	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)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
20.00	Interim payments	0	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)	0	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 - SWING BEDS

Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-2 | Date/Time Prepared: 5/22/2017 10:32 am

Title XIX | 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)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		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)	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	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)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	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)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0		16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
20.00	Interim payments	0		20.00
21.00	Tentative settlement (for contractor use only)	0		21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1331	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part V Date/Time Prepared: 5/22/2017 10:32 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,123,287	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)	5,123,287	4.00
5.00	Primary payer payments	549	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,173,971	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)	5,173,971	19.00
20.00	Deductibles (exclude professional component)	600,124	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,573,847	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	4,573,847	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	63,607	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	41,345	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	33,276	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,615,192	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)	4,615,192	30.00
30.01	Sequestration adjustment (see instructions)	92,304	30.01
31.00	Interim payments	4,383,410	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)	139,478	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	32,473	34.00

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

Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/22/2017 10:32 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,687,879	0	0	0	1.00
2.00	Temporary investments	3,683,856	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	24,474,925	0	0	0	4.00
5.00	Other receivable	1,719,851	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-17,395,094	0	0	0	6.00
7.00	Inventory	1,088,601	0	0	0	7.00
8.00	Prepaid expenses	736,348	0	0	0	8.00
9.00	Other current assets	70,501	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)	16,066,867	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,001,138	0	0	0	12.00
13.00	Land improvements	3,379,433	0	0	0	13.00
14.00	Accumulated depreciation	-2,111,604	0	0	0	14.00
15.00	Buildings	40,621,083	0	0	0	15.00
16.00	Accumulated depreciation	-18,379,315	0	0	0	16.00
17.00	Leasehold improvements	4,288,803	0	0	0	17.00
18.00	Accumulated depreciation	-1,723,099	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	26,949,510	0	0	0	23.00
24.00	Accumulated depreciation	-23,685,734	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)	32,340,215	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	8,449,530	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	656,326	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,105,856	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	57,512,938	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,117,618	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,248,393	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,158,549	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,524,560	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,185,661	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	4,885,985	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12,071,646	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,596,206	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	39,916,732				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)	39,916,732	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	57,512,938	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/22/2017 10:32 am

		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		40,277,092		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-365,152				2.00
3.00	Total (sum of line 1 and line 2)		39,911,940		0		3.00
4.00	RECONCILIATION	4,792		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)		4,792		0		10.00
11.00	Subtotal (line 3 plus line 10)		39,916,732		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		39,916,732		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	RECONCILIATION		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/22/2017 10:32 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	14,581,806		14,581,806	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	14,581,806		14,581,806	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,869,067		3,869,067	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)	3,869,067		3,869,067	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	18,450,873		18,450,873	17.00
18.00	Ancillary services	13,244,651	77,483,894	90,728,545	18.00
19.00	Outpatient services	93,135	16,770,694	16,863,829	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		797,498	797,498	22.00
23.00	AMBULANCE SERVICES	0	7,727,360	7,727,360	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NONREIMBURSABLE COST CENTER	0	11,486,277	11,486,277	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	31,788,659	114,265,723	146,054,382	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		52,000,401		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		52,000,401		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-3 | Date/Time Prepared: 5/22/2017 10:32 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	146,054,382	1.00
2.00	Less contractual allowances and discounts on patients' accounts	97,252,588	2.00
3.00	Net patient revenues (line 1 minus line 2)	48,801,794	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	52,000,401	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,198,607	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	6,045	6.00
7.00	Income from investments	-38,882	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	5,028	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	139,912	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	43,240	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	249,195	22.00
23.00	Governmental appropriations	57,382	23.00
24.00	OTHER REVENUE	1,298,843	24.00
24.01	MOB	927,474	24.01
25.00	Total other income (sum of lines 6-24)	2,688,237	25.00
26.00	Total (line 5 plus line 25)	-510,370	26.00
27.00	OTHER EXPENSES	-145,218	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-145,218	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-365,152	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1331 HHA CCN: 15-7242 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H | Date/Time Prepared: 5/22/2017 10:32 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	102,261	0	0	0	116,477	218,738	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	200,155	0	12,948	0	0	213,103	6.00
7.00	Physical Therapy	152,965	0	8,550	0	0	161,515	7.00
8.00	Occupational Therapy	34,832	0	1,953	0	0	36,785	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	114,785	0	18,743	0	0	133,528	11.00
12.00	Supplies (see instructions)	0	0	0	0	2,599	2,599	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	604,998	0	42,194	0	119,076	766,268	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	218,738	-17,064	201,674			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	213,103	0	213,103			6.00
7.00	Physical Therapy	0	161,515	0	161,515			7.00
8.00	Occupational Therapy	0	36,785	0	36,785			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	133,528	0	133,528			11.00
12.00	Supplies (see instructions)	0	2,599	0	2,599			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	766,268	-17,064	749,204			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 15-1331
HHA CCN: 15-7242

Period: From 01/01/2016 To 12/31/2016

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	201,674	0	0	0	0	201,674	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	213,103	0	0	0	0	213,103	6.00
7.00	Physical Therapy	161,515	0	0	0	0	161,515	7.00
8.00	Occupational Therapy	36,785	0	0	0	0	36,785	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	133,528	0	0	0	0	133,528	11.00
12.00	Supplies (see instructions)	2,599	0	0	0	0	2,599	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	749,204	0	0	0	0	749,204	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	201,674			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	78,494	291,597		6.00
7.00	Physical Therapy	59,491	221,006		7.00
8.00	Occupational Therapy	13,549	50,334		8.00
9.00	Speech Pathology	0	0		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Home Health Aide	49,183	182,711		11.00
12.00	Supplies (see instructions)	957	3,556		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		749,204		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-1331 HHA CCN: 15-7242 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-1 Part II Date/Time Prepared: 5/22/2017 10:32 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-201,674	547,530	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	213,103	6.00
7.00	Physical Therapy	0	0	0	0	0	161,515	7.00
8.00	Occupational Therapy	0	0	0	0	0	36,785	8.00
9.00	Speech Pathology	0	0	0	0	0	0	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	133,528	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	2,599	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-201,674	547,530	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		201,674	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.368334	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1331 | HHA CCN: 15-7242 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-2 Part I | Date/Time Prepared: 5/22/2017 10:32 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP	AMB EQUIP	
		0	1.00	1.01	1.02	2.00	2.01	
1.00	Administrative and General	0	0	30,322	0	0	0	1.00
2.00	Skilled Nursing Care	291,597	0	0	0	0	0	2.00
3.00	Physical Therapy	221,006	0	0	0	0	0	3.00
4.00	Occupational Therapy	50,334	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	182,711	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	3,556	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	749,204	0	30,322	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	OTHER A&G	ADMITTING	PATIENT ACCOUNTING	OPERATION OF PLANT	
		4.00	4A	5.01	5.02	5.03	7.00	
1.00	Administrative and General	138,570	168,892	16,883	3,613	6,821	0	1.00
2.00	Skilled Nursing Care	0	291,597	29,150	0	0	0	2.00
3.00	Physical Therapy	0	221,006	22,093	0	0	0	3.00
4.00	Occupational Therapy	0	50,334	5,032	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	182,711	18,265	0	0	0	7.00
8.00	Supplies (see instructions)	0	3,556	355	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	138,570	918,096	91,778	3,613	6,821	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					21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1331 | HHA CCN: 15-7242 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-2 Part I | Date/Time Prepared: 5/22/2017 10:32 am

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	Cost Center Description	AMB PLANT OPS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.01	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	0	0	0	93,070	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	93,070	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	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	16.00	17.00	24.00	25.00	26.00	
1.00	Administrative and General	0	7,152	0	296,431	0	296,431	1.00
2.00	Skilled Nursing Care	0	0	0	320,747	0	320,747	2.00
3.00	Physical Therapy	0	0	0	243,099	0	243,099	3.00
4.00	Occupational Therapy	0	0	0	55,366	0	55,366	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	200,976	0	200,976	7.00
8.00	Supplies (see instructions)	0	0	0	3,911	0	3,911	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	7,152	0	1,120,530	0	1,120,530	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1331
HHA CCN: 15-7242

Period: From 01/01/2016 To 12/31/2016

Worksheet H-2 Part I
Date/Time Prepared: 5/22/2017 10:32 am

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	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs			
		27.00	28.00			
1.00	Administrative and General					1.00
2.00	Skilled Nursing Care	115,374	436,121			2.00
3.00	Physical Therapy	87,443	330,542			3.00
4.00	Occupational Therapy	19,915	75,281			4.00
5.00	Speech Pathology	0	0			5.00
6.00	Medical Social Services	0	0			6.00
7.00	Home Health Aide	72,292	273,268			7.00
8.00	Supplies (see instructions)	1,407	5,318			8.00
9.00	Drugs	0	0			9.00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11.00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	0			13.00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15.00
16.00	Day Care Program	0	0			16.00
17.00	Home Delivered Meals Program	0	0			17.00
18.00	Homemaker Service	0	0			18.00
19.00	All Others (specify)	0	0			19.00
19.50	Telemedicine	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	296,431	1,120,530			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.	0.359703				21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1331 | HHA CCN: 15-7242 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-2 Part II | Date/Time Prepared: 5/22/2017 10:32 am

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	Cost Center Description	CAPITAL RELATED COSTS						
		NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	AMB EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		1.00	1.01	1.02	2.00	2.01	4.00	
1.00	Administrative and General	0	1,143	0	0	0	604,998	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	1,143	0	0	0	604,998	20.00
21.00	Total cost to be allocated	0	30,322	0	0	0	138,570	21.00
22.00	Unit cost multiplier	0.000000	26.528434	0.000000	0.000000	0.000000	0.229042	22.00

	Cost Center Description	Reconciliation	OTHER A&G (ACCUM COST)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	OPERATION OF PLANT (SQUARE FEET)	AMB PLANT OPS (SQUARE FEET)	
		5A.01	5.01	5.02	5.03	7.00	7.01	
1.00	Administrative and General	0	168,892	797,498	797,498	0	0	1.00
2.00	Skilled Nursing Care	0	291,597	0	0	0	0	2.00
3.00	Physical Therapy	0	221,006	0	0	0	0	3.00
4.00	Occupational Therapy	0	50,334	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	182,711	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	3,556	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)		918,096	797,498	797,498	0	0	20.00
21.00	Total cost to be allocated		91,778	3,613	6,821	0	0	21.00
22.00	Unit cost multiplier		0.099966	0.004530	0.008553	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1331 HHA CCN: 15-7242

Period: From 01/01/2016 To 12/31/2016

Worksheet H-2 Part II Date/Time Prepared: 5/22/2017 10:32 am

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	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	0	0	0	23,363	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	23,363	0	20.00
21.00	Total cost to be allocated	0	0	0	0	93,070	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	3.983649	0.000000	22.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)					
		16.00	17.00					
1.00	Administrative and General	797,498	0					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19)	797,498	0					20.00
21.00	Total cost to be allocated	7,152	0					21.00
22.00	Unit cost multiplier	0.008968	0.000000					22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1331 | HHA CCN: 15-7242 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-3 Part I | Date/Time Prepared: 5/22/2017 10:32 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	436,121		436,121	1,969	221.49	1.00
2.00	Physical Therapy	3.00	330,542	0	330,542	748	441.90	2.00
3.00	Occupational Therapy	4.00	75,281	0	75,281	304	247.63	3.00
4.00	Speech Pathology	5.00	0	0	0	0	0.00	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	273,268		273,268	4,606	59.33	6.00
7.00	Total (sum of lines 1-6)		1,115,212	0	1,115,212	7,627		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		31140	0	1,050			8.00
8.01	Skilled Nursing Care		99915	0	272			8.01
9.00	Physical Therapy		31140	0	578			9.00
9.01	Physical Therapy		99915	0	113			9.01
10.00	Occupational Therapy		31140	0	224			10.00
10.01	Occupational Therapy		99915	0	24			10.01
11.00	Speech Pathology		31140	0	0			11.00
11.01	Speech Pathology		99915	0	0			11.01
12.00	Medical Social Services		31140	0	0			12.00
12.01	Medical Social Services		99915	0	0			12.01
13.00	Home Health Aide		31140	0	446			13.00
13.01	Home Health Aide		99915	0	14			13.01
14.00	Total (sum of lines 8-13)			0	2,721			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	5,318	0	5,318	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,322		0	292,810		1.00
2.00	Physical Therapy	0	691		0	305,353		2.00
3.00	Occupational Therapy	0	248		0	61,412		3.00
4.00	Speech Pathology	0	0		0	0		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	460		0	27,292		6.00
7.00	Total (sum of lines 1-6)	0	2,721		0	686,867		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1331 | HHA CCN: 15-7242 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-3 Part I | Date/Time Prepared: 5/22/2017 10:32 am

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

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	292,810						1.00
2.00	Physical Therapy	305,353						2.00
3.00	Occupational Therapy	61,412						3.00
4.00	Speech Pathology	0						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	27,292						6.00
7.00	Total (sum of lines 1-6)	686,867						7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1331
HHA CCN: 15-7242

Period:
From 01/01/2016
To 12/31/2016

Worksheet H-3
Part II
Date/Time Prepared:
5/22/2017 10:32 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.354786	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.216632	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.022046	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.438262	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.403385	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-1331 | HHA CCN: 15-7242 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/22/2017 10:32 am

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	390,642	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	10,144	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	9,575	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	5,455	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	1,339	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	417,155	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	417,155	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	417,155	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	417,155	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	417,155	31.00
31.01	Sequestration adjustment (see instructions)	0	8,343	31.01
32.00	Interim payments (see instructions)	0	408,812	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 15-1331 | HHA CCN: 15-7242 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-5 | Date/Time Prepared: 5/22/2017 10:32 am

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		408,812	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		408,812	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		408,812	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00