Health Financial Systems | GIBSON GENERAL HOSPITAL | In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151319	Period: From 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 2/23/2016 2:03 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/23/2016 Time: 2:03 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GIBSON GENERAL HOSPITAL (151319) for the cost reporting period beginning 10/01/2014 and ending 09/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 2/23/2016 Time: 2:03 pm
t7WxMbEs1624w4zrbPKUQ4LR6or0p0
:Y:RD0Mrov7azVFnkaHHfu3K4jOUgs
tMDSOcLthHOzCPC4

PI: Date: 2/23/2016 Time: 2:03 pm
KH1JgvI4Ol6RLCzPd:JR5Tn1ECOdS0
nq33jOrKnaTzoE7:NKNv:c6zv9cpxy
e5RhONTaSoOkmcxu

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

EMMETT C. SCHUSTER
PRESIDENT & CEO

Title

25 Feb 2016

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	128,151	-229,011	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	101,664	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	-1		0	9.00
200.00	Total	0	229,815	-229,012	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: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2016 2:01 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1800 SHERMAN DRIVE	PO Box:			1.00
2.00	City: PRINCETON	State: IN	Zip Code: 47670-	County: GIBSON	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	GIBSON GENERAL HOSPITAL	151319	21780	1	12/16/2003	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GIBSON GENERAL SWING BED	15Z319	21780		12/16/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	GIBSON HOME HEALTH	157445	21780		10/19/1995	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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2014	09/30/2015	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(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

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		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
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.				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
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

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		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: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2016 2:01 pm

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

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

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	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
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151319	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/23/2016 2:01 pm

		1.00	2.00	
	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		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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2014	09/30/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151319	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/23/2016 2:01 pm

		1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)	N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/23/2016 2:01 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		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	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	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	01/04/2016	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 2/23/2016 2:01 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
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.	RICH	FERRIELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923832	RFERRIELL@ALLIANTMANAGEMENT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/23/2016 2:01 pm

		Part B Date			
		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)	01/04/2016			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			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.		REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/23/2016 2:01 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	20	7,300	30,912.00	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)		20	7,300	30,912.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	4,560.00	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						13.00
14.00	Total (see instructions)		25	9,125	35,472.00	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	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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						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: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2016 2:01 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	863	70	1,288			1.00
2.00	HMO and other (see instructions)	23	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	377	0	377			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		65	65			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,240	135	1,730			7.00
8.00	INTENSIVE CARE UNIT	131	0	190			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)	1,371	135	1,920	0.00	261.65	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	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,663	276	4,883	0.00	5.93	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						26.25
27.00	Total (sum of lines 14-26)				0.00	267.58	27.00
28.00	Observation Bed Days		0	347			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2016 2:01 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	274	26	433	1.00
2.00	HMO and other (see instructions)			4	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	274	26	433	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	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part IV Date/Time Prepared: 2/23/2016 2:01 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	191,235	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2,176,826	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	209,696	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	982,367	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	16,079	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,576,203	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 151319 | Component CCN: 157445 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-4 | Date/Time Prepared: 2/23/2016 2:01 pm

Home Health Agency I | PPS

					1.00		
0.00	County				GIBSON		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	117.00	0.00	96.00	213.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			21780			20.00
		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	1,215	87	29	6	1,337	21.00
22.00	Skilled Nursing Visit Charges	157,172	11,257	3,751	776	172,956	22.00
23.00	Physical Therapy Visits	952	15	6	7	980	23.00
24.00	Physical Therapy Visit Charges	125,397	1,976	790	922	129,085	24.00
25.00	Occupational Therapy Visits	192	0	2	0	194	25.00
26.00	Occupational Therapy Visit Charges	25,290	0	263	0	25,553	26.00
27.00	Speech Pathology Visits	16	0	0	0	16	27.00
28.00	Speech Pathology Visit Charges	2,108	0	0	0	2,108	28.00
29.00	Medical Social Service Visits	7	0	0	0	7	29.00
30.00	Medical Social Service Visit Charges	1,229	0	0	0	1,229	30.00
31.00	Home Health Aide Visits	458	59	4	9	530	31.00
32.00	Home Health Aide Visit Charges	33,150	4,270	290	651	38,361	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,840	161	41	22	3,064	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)	344,346	17,503	5,094	2,349	369,292	35.00
36.00	Total Number of Episodes (standard/non outlier)	145		17	2	164	36.00
37.00	Total Number of Outlier Episodes		4		0	4	37.00
38.00	Total Non-Routine Medical Supply Charges	3,477	494	15	0	3,986	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-7 | Date/Time Prepared: 2/23/2016 2:01 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	12/16/2003	2.00

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-7 | Date/Time Prepared: 2/23/2016 2:01 pm

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

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	21780	21780	201.00

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-10 | Date/Time Prepared: 2/23/2016 2:01 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.373148	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,504,212	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	8,804,895	6.00
7.00	Medicaid cost (line 1 times line 6)	3,285,529	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,781,317	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,781,317	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	392,951	360,555	753,506	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	146,629	134,540	281,169	21.00
22.00	Partial payment by patients approved for charity care	43,393	16,947	60,340	22.00
23.00	Cost of charity care (line 21 minus line 22)	103,236	117,593	220,829	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,898,303	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	241,299	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	3,657,004	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,364,604	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,585,433	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,366,750	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/23/2016 2:01 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,392,273	1,392,273	-539,328	852,945	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	1,203,988	1,203,988	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	132,088	702,019	834,107	462,206	1,296,313	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,742,253	3,690,503	5,432,756	-2,352	5,430,404	5.00
7.00	00700	OPERATION OF PLANT	267,400	946,692	1,214,092	-14,250	1,199,842	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	37,184	46,052	83,236	-953	82,283	8.00
9.00	00900	HOUSEKEEPING	293,341	168,637	461,978	-7,843	454,135	9.00
10.00	01000	DIETARY	406,063	421,360	827,423	-428,056	399,367	10.00
11.00	01100	CAFETERIA	0	0	0	418,524	418,524	11.00
13.00	01300	NURSING ADMINISTRATION	145,276	16,043	161,319	0	161,319	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	240,824	156,132	396,956	-4,482	392,474	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,012,202	472,047	1,484,249	-95,038	1,389,211	30.00
31.00	03100	INTENSIVE CARE UNIT	154,002	52,103	206,105	-5,302	200,803	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	698,540	1,224,213	1,922,753	-305,828	1,616,925	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	649,565	740,998	1,390,563	-38,597	1,351,966	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	151,435	151,435	0	151,435	54.03
60.00	06000	LABORATORY	708,778	911,977	1,620,755	-32,486	1,588,269	60.00
65.00	06500	RESPIRATORY THERAPY	395,787	333,211	728,998	-38,148	690,850	65.00
66.00	06600	PHYSICAL THERAPY	645,999	272,316	918,315	-82,526	835,789	66.00
67.00	06700	OCCUPATIONAL THERAPY	232,605	59,218	291,823	-2,104	289,719	67.00
68.00	06800	SPEECH PATHOLOGY	121,605	51,937	173,542	-2,841	170,701	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-4,313	-4,313	135,935	131,622	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	231,508	231,508	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	166,408	1,127,492	1,293,900	-41,124	1,252,776	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,754	14,377	24,131	-4,547	19,584	90.00
90.01	09001	DIABETES	29,264	27,969	57,233	-1,142	56,091	90.01
90.02	09002	OP PSYCH	82,089	90,796	172,885	-1,749	171,136	90.02
90.03	09003	PAIN MANAGEMENT	136,524	72,473	208,997	-2,620	206,377	90.03
91.00	09100	EMERGENCY	807,497	767,618	1,575,115	-28,870	1,546,245	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	308,269	153,263	461,532	-6,203	455,329	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		234,341	234,341	-234,341	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,423,317	14,293,182	23,716,499	531,431	24,247,930	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	3,707,026	2,780,020	6,487,046	-507,172	5,979,874	194.00
194.01	07951	FOUNDATION	50,498	5,923	56,421	0	56,421	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	1,264,146	486,282	1,750,428	-24,259	1,726,169	194.03
200.00		TOTAL (SUM OF LINES 118-199)	14,444,987	17,565,407	32,010,394	0	32,010,394	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/23/2016 2:01 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-17,867	835,078		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-213,098	990,890		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	52,141	1,348,454		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-634,758	4,795,646		5.00
7.00	00700	OPERATION OF PLANT	-10,013	1,189,829		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	82,283		8.00
9.00	00900	HOUSEKEEPING	0	454,135		9.00
10.00	01000	DIETARY	0	399,367		10.00
11.00	01100	CAFETERIA	-163,200	255,324		11.00
13.00	01300	NURSING ADMINISTRATION	0	161,319		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-14,867	377,607		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-40,291	1,348,920		30.00
31.00	03100	INTENSIVE CARE UNIT	0	200,803		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-325,000	1,291,925		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,351,966		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	151,435		54.03
60.00	06000	LABORATORY	-43,333	1,544,936		60.00
65.00	06500	RESPIRATORY THERAPY	-40,146	650,704		65.00
66.00	06600	PHYSICAL THERAPY	0	835,789		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	289,719		67.00
68.00	06800	SPEECH PATHOLOGY	0	170,701		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	131,622		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	231,508		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,252,776		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	19,584		90.00
90.01	09001	DIABETES	0	56,091		90.01
90.02	09002	OP PSYCH	-59,124	112,012		90.02
90.03	09003	PAIN MANAGEMENT	-1,059	205,318		90.03
91.00	09100	EMERGENCY	0	1,546,245		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	CARDIAC REHAB	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	455,329		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,510,615	22,737,315		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	MOB	0	5,979,874		194.00
194.01	07951	FOUNDATION	0	56,421		194.01
194.02	07952	ASC	0	0		194.02
194.03	07953	SNF - PERRY CO.	0	1,726,169		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-1,510,615	30,499,779		200.00

RECLASSIFICATIONS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/23/2016 2:01 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INSURANCE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	20,204		1.00
	TOTALS		0	20,204		
	B - DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	495,992		1.00
	TOTALS		0	495,992		
	D - CAFETERIA					
1.00	CAFETERIA	11.00	205,393	213,131		1.00
	TOTALS		205,393	213,131		
	E - MED SUPPLY CHG PTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	135,935		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	231,508		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	64		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
	TOTALS		0	367,507		
	F - RENTAL EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	436,124		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
24.00		0.00	0	0		24.00
27.00		0.00	0	0		27.00
	TOTALS		0	436,124		
	H - BUSINESS HEALTH SER					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	96,728	76,620		1.00
	TOTALS		96,728	76,620		
	I - INTEREST					
1.00		0.00	0	0		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	228,536		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	5,805		3.00
	TOTALS		0	234,341		
	J - PROPERTY TAX					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	23,132		1.00
	TOTALS		0	23,132		
	K - QUALITY SERVICES					
1.00	ADMINISTRATIVE & GENERAL	5.00	37,160	24,712		1.00
	TOTALS		37,160	24,712		
	L - HEALTH INSURANCE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	212,287		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00

RECLASSIFICATIONS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/23/2016 2:01 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
	TOTALS		0	212,287		
	M - WELLNESS CENTER					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	48,173	28,398		1.00
	TOTALS		48,173	28,398		
500.00	Grand Total: Increases		387,454	2,132,448		500.00

RECLASSIFICATIONS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/23/2016 2:01 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INSURANCE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	20,204	9		1.00
	TOTALS		0	20,204			
	B - DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	495,992	9		1.00
	TOTALS		0	495,992			
	D - CAFETERIA						
1.00	DIETARY	10.00	205,393	213,131	0		1.00
	TOTALS		205,393	213,131			
	E - MED SUPPLY CHG PTS						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	1,274	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	229	0		5.00
6.00	SNF - PERRY CO.	194.03	0	646	0		6.00
7.00	OPERATING ROOM	50.00	0	205,743	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	79	0		8.00
10.00	LABORATORY	60.00	0	1,556	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	14,630	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	4,348	0		12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	0	154	0		13.00
14.00	PAIN MANAGEMENT	90.03	0	244	0		14.00
15.00	EMERGENCY	91.00	0	6,034	0		15.00
16.00	HOME HEALTH AGENCY	101.00	0	806	0		16.00
17.00	MOB	194.00	0	131,764	0		17.00
	TOTALS		0	367,507			
	F - RENTAL EXPENSE						
1.00		0.00	0	0	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	32,167	0		2.00
3.00	OPERATION OF PLANT	7.00	0	8,660	0		3.00
9.00	ADULTS & PEDIATRICS	30.00	0	14,460	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	3,122	0		10.00
11.00	SNF - PERRY CO.	194.03	0	909	0		11.00
12.00	OPERATING ROOM	50.00	0	93,165	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	27,353	0		13.00
15.00	LABORATORY	60.00	0	22,624	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	20,722	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	71,130	0		17.00
21.00	DRUGS CHARGED TO PATIENTS	73.00	0	38,844	0		21.00
22.00	CLINIC	90.00	0	4,547	0		22.00
24.00	EMERGENCY	91.00	0	8,972	0		24.00
27.00	MOB	194.00	0	89,449	0		27.00
	TOTALS		0	436,124			
	H - BUSINESS HEALTH SER						
1.00	MOB	194.00	96,728	76,620	0		1.00
	TOTALS		96,728	76,620			
	I - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	234,341	0		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	234,341			
	J - PROPERTY TAX						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	23,132	9		1.00
	TOTALS		0	23,132			
	K - QUALITY SERVICES						
1.00	ADULTS & PEDIATRICS	30.00	37,160	24,712	0		1.00
	TOTALS		37,160	24,712			
	L - HEALTH INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	37,926	0		1.00
2.00	OPERATION OF PLANT	7.00	0	5,590	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	953	0		3.00
4.00	HOUSEKEEPING	9.00	0	7,843	0		4.00
5.00	DIETARY	10.00	0	9,532	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,482	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	17,432	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	1,951	0		8.00
9.00	SNF - PERRY CO.	194.03	0	22,704	0		9.00
10.00	OPERATING ROOM	50.00	0	6,920	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,165	0		11.00
12.00	LABORATORY	60.00	0	8,306	0		12.00

RECLASSIFICATIONS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/23/2016 2:01 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
13.00	RESPIRATORY THERAPY	65.00	0	2,796	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	7,048	0		14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	2,104	0		15.00
16.00	SPEECH PATHOLOGY	68.00	0	2,841	0		16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,126	0		17.00
18.00	DIABETES	90.01	0	1,142	0		18.00
19.00	OP PSYCH	90.02	0	1,749	0		19.00
20.00	PAIN MANAGEMENT	90.03	0	2,376	0		20.00
21.00	EMERGENCY	91.00	0	13,864	0		21.00
22.00	HOME HEALTH AGENCY	101.00	0	5,397	0		22.00
23.00	MOB	194.00	0	36,040	0		23.00
	TOTALS		0	212,287			
	M - WELLNESS CENTER						
1.00	MOB	194.00	48,173	28,398	0		1.00
	TOTALS		48,173	28,398			
500.00	Grand Total: Decreases		387,454	2,132,448			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 2/23/2016 2:01 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	679,512	5,290	0	5,290	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,332,050	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	13,573,310	289,973	0	289,973	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,584,872	295,263	0	295,263	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	33,584,872	295,263	0	295,263	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	684,802	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	19,332,050	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	13,863,283	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,880,135	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	33,880,135	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 2/23/2016 2:01 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,392,273	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,392,273	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,392,273		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	1,392,273		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 2/23/2016 2:01 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,392,273	0	1,392,273	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	1,392,273	0	1,392,273	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	835,078	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,203,988	-213,098	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,039,066	-213,098	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	835,078	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	990,890	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,825,968	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/23/2016 2:01 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-213,098	NEW CAP REL COSTS-MVBLE EQUIP	2.00	10	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-10,013	OPERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-507,894			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	-163,200	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	-14,867	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	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	-17,867	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/23/2016 2:01 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	MISC INCOME	B	-33,621	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01			0		0.00	0	33.01
33.02	PHYSICIAN RECRUITING	A	-16,541	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ADVERTISING	A	-271,736	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	ADVERTISING	A	-1,059	PAIN MANAGEMENT	90.03	0	33.04
34.00	EMPLOYEE DISCOUNT	A	52,141	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00
35.00	HAF FEE	A	-312,860	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00			0		0.00	0	36.00
37.00			0		0.00	0	37.00
38.00			0		0.00	0	38.00
39.00			0		0.00	0	39.00
40.00			0		0.00	0	40.00
41.00			0		0.00	0	41.00
42.00			0		0.00	0	42.00
43.00			0		0.00	0	43.00
44.00			0		0.00	0	44.00
45.00			0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,510,615				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: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 2/23/2016 2:01 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	40,291	40,291	0	0	0	1.00
2.00	50.00	OPERATING ROOM	325,000	325,000	0	0	0	2.00
3.00	60.00	LABORATORY	43,333	43,333	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	84,171	40,146	44,025	0	0	4.00
5.00	90.01	DIABETES	5,000	0	5,000	0	0	5.00
6.00	90.02	OP PSYCH	59,124	59,124	0	0	0	6.00
7.00	91.00	EMERGENCY	348,900	0	348,900	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			905,819	507,894	397,925		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	90.01	DIABETES	0	0	0	0	0	5.00
6.00	90.02	OP PSYCH	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	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	30.00	ADULTS & PEDIATRICS	0	0	0	40,291		1.00
2.00	50.00	OPERATING ROOM	0	0	0	325,000		2.00
3.00	60.00	LABORATORY	0	0	0	43,333		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	40,146		4.00
5.00	90.01	DIABETES	0	0	0	0		5.00
6.00	90.02	OP PSYCH	0	0	0	59,124		6.00
7.00	91.00	EMERGENCY	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	507,894		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/23/2016 2:01 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	835,078	835,078				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	990,890		990,890			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,348,454	5,140	6,099	1,359,693		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,795,646	40,727	48,326	170,768	5,055,467	5.00
7.00	00700	OPERATION OF PLANT	1,189,829	158,117	187,616	25,662	1,561,224	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	82,283	14,855	17,626	3,569	118,333	8.00
9.00	00900	HOUSEKEEPING	454,135	8,384	9,949	28,152	500,620	9.00
10.00	01000	DIETARY	399,367	38,139	45,255	19,258	502,019	10.00
11.00	01100	CAFETERIA	255,324	0	0	19,711	275,035	11.00
13.00	01300	NURSING ADMINISTRATION	161,319	2,515	2,985	13,942	180,761	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	377,607	12,148	14,415	23,112	427,282	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,348,920	74,565	88,478	93,574	1,605,537	30.00
31.00	03100	INTENSIVE CARE UNIT	200,803	17,643	20,935	14,779	254,160	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,291,925	46,514	55,193	67,038	1,460,670	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,351,966	31,860	37,805	62,338	1,483,969	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	151,435	3,828	4,542	0	159,805	54.03
60.00	06000	LABORATORY	1,544,936	13,943	16,545	68,021	1,643,445	60.00
65.00	06500	RESPIRATORY THERAPY	650,704	14,691	17,432	37,983	720,810	65.00
66.00	06600	PHYSICAL THERAPY	835,789	25,617	30,397	61,996	953,799	66.00
67.00	06700	OCCUPATIONAL THERAPY	289,719	7,455	8,846	22,323	328,343	67.00
68.00	06800	SPEECH PATHOLOGY	170,701	565	670	11,670	183,606	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	131,622	32,708	38,810	0	203,140	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	231,508	0	0	0	231,508	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,252,776	9,223	10,943	15,970	1,288,912	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	19,584	0	0	936	20,520	90.00
90.01	09001	DIABETES	56,091	12,740	15,118	2,808	86,757	90.01
90.02	09002	OP PSYCH	112,012	1,832	2,174	7,878	123,896	90.02
90.03	09003	PAIN MANAGEMENT	205,318	0	0	13,102	218,420	90.03
91.00	09100	EMERGENCY	1,546,245	80,643	95,690	77,495	1,800,073	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	455,329	4,602	5,461	29,584	494,976	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,737,315	658,454	781,310	891,669	21,883,087	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	5,979,874	77,791	92,306	341,859	6,491,830	194.00
194.01	07951	FOUNDATION	56,421	11,929	14,155	4,846	87,351	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	1,726,169	86,904	103,119	121,319	2,037,511	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	30,499,779	835,078	990,890	1,359,693	30,499,779	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/23/2016 2:01 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,055,467					5.00
7.00	00700	OPERATION OF PLANT	310,196	1,871,420				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,511	44,049	185,893			8.00
9.00	00900	HOUSEKEEPING	99,467	24,862	8,041	632,990		9.00
10.00	01000	DIETARY	99,745	113,096	2,168	39,716	756,744	10.00
11.00	01100	CAFETERIA	54,646	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	35,915	7,459	0	2,619	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	84,896	36,023	0	12,650	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	319,001	221,111	57,247	77,648	220,011	30.00
31.00	03100	INTENSIVE CARE UNIT	50,499	52,319	945	18,373	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	290,218	137,931	7,665	48,437	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	294,847	94,476	7,198	33,177	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	31,751	11,350	0	3,986	0	54.03
60.00	06000	LABORATORY	326,533	41,347	0	14,520	0	60.00
65.00	06500	RESPIRATORY THERAPY	143,216	43,563	4,344	15,298	0	65.00
66.00	06600	PHYSICAL THERAPY	189,508	75,965	11,198	26,677	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	65,238	22,106	0	7,763	0	67.00
68.00	06800	SPEECH PATHOLOGY	36,480	1,675	0	588	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,361	96,990	0	34,060	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,998	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	256,091	27,348	0	9,604	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,077	0	0	0	0	90.00
90.01	09001	DIABETES	17,238	37,780	0	13,267	0	90.01
90.02	09002	OP PSYCH	24,617	5,432	0	1,908	0	90.02
90.03	09003	PAIN MANAGEMENT	43,397	0	0	0	0	90.03
91.00	09100	EMERGENCY	357,653	239,136	17,426	83,978	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	98,346	13,647	0	4,793	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,343,445	1,347,665	116,232	449,062	220,011	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	1,289,837	230,678	0	81,008	0	194.00
194.01	07951	FOUNDATION	17,356	35,375	0	12,423	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	404,829	257,702	69,661	90,497	536,733	194.03
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)	5,055,467	1,871,420	185,893	632,990	756,744	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/23/2016 2:01 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	329,681					11.00
13.00	01300	NURSING ADMINISTRATION	2,353	229,107				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,670	0	578,521			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	44,164	64,589	160,891	2,770,199	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,000	8,775	4,108	395,179	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,775	0	71,887	2,035,583	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,352	0	58,537	2,000,556	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	206,892	0	54.03
60.00	06000	LABORATORY	35,363	0	44,159	2,105,367	0	60.00
65.00	06500	RESPIRATORY THERAPY	15,082	0	14,377	956,690	0	65.00
66.00	06600	PHYSICAL THERAPY	27,716	0	65,383	1,350,246	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,023	0	0	431,473	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,835	0	0	226,184	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,188	0	0	376,739	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	277,506	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,129	0	0	1,587,084	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	423	0	342	25,362	0	90.00
90.01	09001	DIABETES	1,930	2,822	0	159,794	0	90.01
90.02	09002	OP PSYCH	3,553	0	0	159,406	0	90.02
90.03	09003	PAIN MANAGEMENT	2,211	0	0	264,028	0	90.03
91.00	09100	EMERGENCY	32,093	46,936	154,729	2,732,024	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	611,762	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	254,860	123,122	574,413	18,672,074	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	0	342	8,093,695	0	194.00
194.01	07951	FOUNDATION	2,353	0	0	154,858	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	72,468	105,985	3,766	3,579,152	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	329,681	229,107	578,521	30,499,779	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/23/2016 2:01 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,770,199		30.00
31.00	03100	INTENSIVE CARE UNIT	395,179		31.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,035,583		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,000,556		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	206,892		54.03
60.00	06000	LABORATORY	2,105,367		60.00
65.00	06500	RESPIRATORY THERAPY	956,690		65.00
66.00	06600	PHYSICAL THERAPY	1,350,246		66.00
67.00	06700	OCCUPATIONAL THERAPY	431,473		67.00
68.00	06800	SPEECH PATHOLOGY	226,184		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	376,739		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	277,506		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,587,084		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	25,362		90.00
90.01	09001	DIABETES	159,794		90.01
90.02	09002	OP PSYCH	159,406		90.02
90.03	09003	PAIN MANAGEMENT	264,028		90.03
91.00	09100	EMERGENCY	2,732,024		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	CARDIAC REHAB	0		93.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	611,762		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,672,074		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	MOB	8,093,695		194.00
194.01	07951	FOUNDATION	154,858		194.01
194.02	07952	ASC	0		194.02
194.03	07953	SNF - PERRY CO.	3,579,152		194.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	30,499,779		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/23/2016 2:01 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,140	6,099	11,239	11,239	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	40,727	48,326	89,053	1,411	5.00
7.00	00700	OPERATION OF PLANT	0	158,117	187,616	345,733	212	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,855	17,626	32,481	29	8.00
9.00	00900	HOUSEKEEPING	0	8,384	9,949	18,333	233	9.00
10.00	01000	DIETARY	0	38,139	45,255	83,394	159	10.00
11.00	01100	CAFETERIA	0	0	0	0	163	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,515	2,985	5,500	115	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,148	14,415	26,563	191	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	74,565	88,478	163,043	773	30.00
31.00	03100	INTENSIVE CARE UNIT	0	17,643	20,935	38,578	122	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	46,514	55,193	101,707	554	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,860	37,805	69,665	515	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	3,828	4,542	8,370	0	54.03
60.00	06000	LABORATORY	0	13,943	16,545	30,488	562	60.00
65.00	06500	RESPIRATORY THERAPY	0	14,691	17,432	32,123	314	65.00
66.00	06600	PHYSICAL THERAPY	0	25,617	30,397	56,014	512	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,455	8,846	16,301	184	67.00
68.00	06800	SPEECH PATHOLOGY	0	565	670	1,235	96	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	32,708	38,810	71,518	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,223	10,943	20,166	132	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	8	90.00
90.01	09001	DIABETES	0	12,740	15,118	27,858	23	90.01
90.02	09002	OP PSYCH	0	1,832	2,174	4,006	65	90.02
90.03	09003	PAIN MANAGEMENT	0	0	0	0	108	90.03
91.00	09100	EMERGENCY	0	80,643	95,690	176,333	640	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	4,602	5,461	10,063	244	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	658,454	781,310	1,439,764	7,365	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	77,791	92,306	170,097	2,832	194.00
194.01	07951	FOUNDATION	0	11,929	14,155	26,084	40	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	86,904	103,119	190,023	1,002	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	835,078	990,890	1,825,968	11,239	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/23/2016 2:01 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	90,464					5.00
7.00	00700	OPERATION OF PLANT	5,550	351,495				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	421	8,273	41,204			8.00
9.00	00900	HOUSEKEEPING	1,780	4,670	1,782	26,798		9.00
10.00	01000	DIETARY	1,785	21,242	481	1,681	108,742	10.00
11.00	01100	CAFETERIA	978	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	643	1,401	0	111	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,519	6,766	0	536	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,708	41,530	12,689	3,287	31,615	30.00
31.00	03100	INTENSIVE CARE UNIT	904	9,827	210	778	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,193	25,907	1,699	2,051	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,276	17,745	1,596	1,405	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	568	2,132	0	169	0	54.03
60.00	06000	LABORATORY	5,842	7,766	0	615	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,562	8,182	963	648	0	65.00
66.00	06600	PHYSICAL THERAPY	3,391	14,268	2,482	1,129	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,167	4,152	0	329	0	67.00
68.00	06800	SPEECH PATHOLOGY	653	315	0	25	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	722	18,217	0	1,442	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	823	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,582	5,137	0	407	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	73	0	0	0	0	90.00
90.01	09001	DIABETES	308	7,096	0	562	0	90.01
90.02	09002	OP PSYCH	440	1,020	0	81	0	90.02
90.03	09003	PAIN MANAGEMENT	776	0	0	0	0	90.03
91.00	09100	EMERGENCY	6,399	44,915	3,863	3,555	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,760	2,563	0	203	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	59,823	253,124	25,765	19,014	31,615	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	23,087	43,327	0	3,430	0	194.00
194.01	07951	FOUNDATION	311	6,644	0	526	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	7,243	48,400	15,439	3,828	77,127	194.03
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)	90,464	351,495	41,204	26,798	108,742	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/23/2016 2:01 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,141					11.00
13.00	01300	NURSING ADMINISTRATION	8	7,778				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	61	0	35,636			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	153	2,193	9,910	270,901	0	30.00
31.00	03100	INTENSIVE CARE UNIT	21	298	253	50,991	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65	0	4,428	141,604	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98	0	3,606	99,906	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	11,239	0	54.03
60.00	06000	LABORATORY	122	0	2,720	48,115	0	60.00
65.00	06500	RESPIRATORY THERAPY	52	0	886	45,730	0	65.00
66.00	06600	PHYSICAL THERAPY	96	0	4,028	81,920	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	28	0	0	22,161	0	67.00
68.00	06800	SPEECH PATHOLOGY	13	0	0	2,337	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8	0	0	91,907	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	823	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18	0	0	30,442	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1	0	21	103	0	90.00
90.01	09001	DIABETES	7	96	0	35,950	0	90.01
90.02	09002	OP PSYCH	12	0	0	5,624	0	90.02
90.03	09003	PAIN MANAGEMENT	8	0	0	892	0	90.03
91.00	09100	EMERGENCY	111	1,593	9,531	246,940	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	14,833	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	882	4,180	35,383	1,202,418	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	0	21	242,794	0	194.00
194.01	07951	FOUNDATION	8	0	0	33,613	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	251	3,598	232	347,143	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,141	7,778	35,636	1,825,968	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/23/2016 2:01 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	270,901		30.00
31.00	03100	INTENSIVE CARE UNIT	50,991		31.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	141,604		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,906		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	11,239		54.03
60.00	06000	LABORATORY	48,115		60.00
65.00	06500	RESPIRATORY THERAPY	45,730		65.00
66.00	06600	PHYSICAL THERAPY	81,920		66.00
67.00	06700	OCCUPATIONAL THERAPY	22,161		67.00
68.00	06800	SPEECH PATHOLOGY	2,337		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	91,907		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	823		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,442		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	103		90.00
90.01	09001	DIABETES	35,950		90.01
90.02	09002	OP PSYCH	5,624		90.02
90.03	09003	PAIN MANAGEMENT	892		90.03
91.00	09100	EMERGENCY	246,940		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	CARDIAC REHAB	0		93.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	14,833		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,202,418		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	MOB	242,794		194.00
194.01	07951	FOUNDATION	33,613		194.01
194.02	07952	ASC	0		194.02
194.03	07953	SNF - PERRY CO.	347,143		194.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	1,825,968		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 2:01 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	91,633					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		91,633				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	564	564	14,167,998			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,469	4,469	1,779,413	-5,055,467	25,444,312	5.00
7.00	00700	OPERATION OF PLANT	17,350	17,350	267,400	0	1,561,224	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,630	1,630	37,184	0	118,333	8.00
9.00	00900	HOUSEKEEPING	920	920	293,341	0	500,620	9.00
10.00	01000	DIETARY	4,185	4,185	200,670	0	502,019	10.00
11.00	01100	CAFETERIA	0	0	205,393	0	275,035	11.00
13.00	01300	NURSING ADMINISTRATION	276	276	145,276	0	180,761	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,333	1,333	240,824	0	427,282	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,182	8,182	975,042	0	1,605,537	30.00
31.00	03100	INTENSIVE CARE UNIT	1,936	1,936	154,002	0	254,160	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,104	5,104	698,540	0	1,460,670	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,496	3,496	649,565	0	1,483,969	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	420	420	0	0	159,805	54.03
60.00	06000	LABORATORY	1,530	1,530	708,778	0	1,643,445	60.00
65.00	06500	RESPIRATORY THERAPY	1,612	1,612	395,787	0	720,810	65.00
66.00	06600	PHYSICAL THERAPY	2,811	2,811	645,999	0	953,799	66.00
67.00	06700	OCCUPATIONAL THERAPY	818	818	232,605	0	328,343	67.00
68.00	06800	SPEECH PATHOLOGY	62	62	121,605	0	183,606	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,589	3,589	0	0	203,140	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	231,508	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,012	1,012	166,408	0	1,288,912	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	9,754	0	20,520	90.00
90.01	09001	DIABETES	1,398	1,398	29,264	0	86,757	90.01
90.02	09002	OP PSYCH	201	201	82,089	0	123,896	90.02
90.03	09003	PAIN MANAGEMENT	0	0	136,524	0	218,420	90.03
91.00	09100	EMERGENCY	8,849	8,849	807,497	0	1,800,073	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	505	505	308,269	0	494,976	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	72,252	72,252	9,291,229	-5,055,467	16,827,620	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	8,536	8,536	3,562,125	0	6,491,830	194.00
194.01	07951	FOUNDATION	1,309	1,309	50,498	0	87,351	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	9,536	9,536	1,264,146	0	2,037,511	194.03
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)	835,078	990,890	1,359,693		5,055,467	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.113289	10.813681	0.095969		0.198688	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			11,239		90,464	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000793		0.003555	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 2:01 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	69,250					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,630	618,515				8.00
9.00	00900	HOUSEKEEPING	920	26,755	66,700			9.00
10.00	01000	DIETARY	4,185	7,215	4,185	61,503		10.00
11.00	01100	CAFETERIA	0	0	0	0	291,448	11.00
13.00	01300	NURSING ADMINISTRATION	276	0	276	0	2,080	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,333	0	1,333	0	15,621	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,182	190,475	8,182	17,881	39,042	30.00
31.00	03100	INTENSIVE CARE UNIT	1,936	3,145	1,936	0	5,304	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,104	25,505	5,104	0	16,598	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,496	23,950	3,496	0	25,064	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	420	0	420	0	0	54.03
60.00	06000	LABORATORY	1,530	0	1,530	0	31,262	60.00
65.00	06500	RESPIRATORY THERAPY	1,612	14,455	1,612	0	13,333	65.00
66.00	06600	PHYSICAL THERAPY	2,811	37,260	2,811	0	24,502	66.00
67.00	06700	OCCUPATIONAL THERAPY	818	0	818	0	7,093	67.00
68.00	06800	SPEECH PATHOLOGY	62	0	62	0	3,390	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,589	0	3,589	0	1,934	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,012	0	1,012	0	4,534	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	374	90.00
90.01	09001	DIABETES	1,398	0	1,398	0	1,706	90.01
90.02	09002	OP PSYCH	201	0	201	0	3,141	90.02
90.03	09003	PAIN MANAGEMENT	0	0	0	0	1,955	90.03
91.00	09100	EMERGENCY	8,849	57,980	8,849	0	28,371	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	505	0	505	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	49,869	386,740	47,319	17,881	225,304	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	8,536	0	8,536	0	0	194.00
194.01	07951	FOUNDATION	1,309	0	1,309	0	2,080	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	9,536	231,775	9,536	43,622	64,064	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,871,420	185,893	632,990	756,744	329,681	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.024116	0.300547	9.490105	12.304180	1.131183	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	351,495	41,204	26,798	108,742	1,141	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.075740	0.066618	0.401769	1.768076	0.003915	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 2:01 pm

		Cost Center Description	NURSING ADMINISTRATION (NRSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION	138,487			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,690		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	39,042	470		30.00
31.00	03100	INTENSIVE CARE UNIT	5,304	12		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	210		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	171		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0		54.03
60.00	06000	LABORATORY	0	129		60.00
65.00	06500	RESPIRATORY THERAPY	0	42		65.00
66.00	06600	PHYSICAL THERAPY	0	191		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 PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	1		90.00
90.01	09001	DIABETES	1,706	0		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	0	0		90.03
91.00	09100	EMERGENCY	28,371	452		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	CARDIAC REHAB	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	74,423	1,678		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	MOB	0	1		194.00
194.01	07951	FOUNDATION	0	0		194.01
194.02	07952	ASC	0	0		194.02
194.03	07953	SNF - PERRY CO.	64,064	11		194.03
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)	229,107	578,521		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.654357	342.320118		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,778	35,636		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.056164	21.086391		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/23/2016 2:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,770,199		2,770,199	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	395,179		395,179	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,035,583		2,035,583	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,000,556		2,000,556	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	206,892		206,892	0	0	54.03
60.00	06000	LABORATORY	2,105,367		2,105,367	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	956,690	0	956,690	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,350,246	0	1,350,246	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	431,473	0	431,473	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	226,184	0	226,184	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	376,739		376,739	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	277,506		277,506	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,587,084		1,587,084	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	25,362		25,362	0	0	90.00
90.01	09001	DIABETES	159,794		159,794	0	0	90.01
90.02	09002	OP PSYCH	159,406		159,406	0	0	90.02
90.03	09003	PAIN MANAGEMENT	264,028		264,028	0	0	90.03
91.00	09100	EMERGENCY	2,732,024		2,732,024	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	475,730		475,730		0	92.00
93.00	04040	CARDIAC REHAB	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	611,762		611,762		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	19,147,804	0	19,147,804	0	0	200.00
201.00		Less Observation Beds	475,730		475,730		0	201.00
202.00		Total (see instructions)	18,672,074	0	18,672,074	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/23/2016 2:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,545,304		1,545,304			30.00
31.00	03100	INTENSIVE CARE UNIT	241,226		241,226			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	496,340	4,506,396	5,002,736	0.406894	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	295,434	10,386,187	10,681,621	0.187290	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	21,224	343,730	364,954	0.566899	0.000000	54.03
60.00	06000	LABORATORY	842,377	7,314,780	8,157,157	0.258101	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	345,328	2,051,277	2,396,605	0.399186	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	745,141	3,696,898	4,442,039	0.303970	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	268,643	1,347,174	1,615,817	0.267031	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	35,902	674,569	710,471	0.318358	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	362,518	266,618	629,136	0.598820	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	523,637	384,870	908,507	0.305453	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	678,591	2,427,610	3,106,201	0.510941	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	DIABETES	0	23,274	23,274	6.865773	0.000000	90.01
90.02	09002	OP PSYCH	0	185,199	185,199	0.860728	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0	711,844	711,844	0.370907	0.000000	90.03
91.00	09100	EMERGENCY	183,856	8,202,033	8,385,889	0.325788	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	13,959	315,130	329,089	1.445597	0.000000	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	602,261	602,261			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,599,480	43,439,850	50,039,330			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,599,480	43,439,850	50,039,330			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/23/2016 2:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		54.03
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 PATIENTS	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	DIABETES	0.000000		90.01
90.02	09002	OP PSYCH	0.000000		90.02
90.03	09003	PAIN MANAGEMENT	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040	CARDIAC REHAB	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
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: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/23/2016 2:01 pm

Title XIX | Hospital | PPS

		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	2,770,199		2,770,199	0	2,770,199	30.00
31.00	03100	INTENSIVE CARE UNIT	395,179		395,179	0	395,179	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,035,583		2,035,583	0	2,035,583	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,000,556		2,000,556	0	2,000,556	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	206,892		206,892	0	206,892	54.03
60.00	06000	LABORATORY	2,105,367		2,105,367	0	2,105,367	60.00
65.00	06500	RESPIRATORY THERAPY	956,690	0	956,690	0	956,690	65.00
66.00	06600	PHYSICAL THERAPY	1,350,246	0	1,350,246	0	1,350,246	66.00
67.00	06700	OCCUPATIONAL THERAPY	431,473	0	431,473	0	431,473	67.00
68.00	06800	SPEECH PATHOLOGY	226,184	0	226,184	0	226,184	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	376,739		376,739	0	376,739	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	277,506		277,506	0	277,506	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,587,084		1,587,084	0	1,587,084	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	25,362		25,362	0	25,362	90.00
90.01	09001	DIABETES	159,794		159,794	0	159,794	90.01
90.02	09002	OP PSYCH	159,406		159,406	0	159,406	90.02
90.03	09003	PAIN MANAGEMENT	264,028		264,028	0	264,028	90.03
91.00	09100	EMERGENCY	2,732,024		2,732,024	0	2,732,024	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	475,730		475,730		475,730	92.00
93.00	04040	CARDIAC REHAB	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	611,762		611,762		611,762	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	19,147,804	0	19,147,804	0	19,147,804	200.00
201.00		Less Observation Beds	475,730		475,730		475,730	201.00
202.00		Total (see instructions)	18,672,074	0	18,672,074	0	18,672,074	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/23/2016 2:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,545,304		1,545,304			30.00
31.00	03100	INTENSIVE CARE UNIT	241,226		241,226			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	496,340	4,506,396	5,002,736	0.406894	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	295,434	10,386,187	10,681,621	0.187290	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	21,224	343,730	364,954	0.566899	0.000000	54.03
60.00	06000	LABORATORY	842,377	7,314,780	8,157,157	0.258101	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	345,328	2,051,277	2,396,605	0.399186	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	745,141	3,696,898	4,442,039	0.303970	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	268,643	1,347,174	1,615,817	0.267031	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	35,902	674,569	710,471	0.318358	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	362,518	266,618	629,136	0.598820	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	523,637	384,870	908,507	0.305453	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	678,591	2,427,610	3,106,201	0.510941	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	DIABETES	0	23,274	23,274	6.865773	0.000000	90.01
90.02	09002	OP PSYCH	0	185,199	185,199	0.860728	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0	711,844	711,844	0.370907	0.000000	90.03
91.00	09100	EMERGENCY	183,856	8,202,033	8,385,889	0.325788	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	13,959	315,130	329,089	1.445597	0.000000	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	602,261	602,261			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,599,480	43,439,850	50,039,330			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,599,480	43,439,850	50,039,330			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/23/2016 2:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.406894		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187290		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.566899		54.03
60.00	06000	LABORATORY	0.258101		60.00
65.00	06500	RESPIRATORY THERAPY	0.399186		65.00
66.00	06600	PHYSICAL THERAPY	0.303970		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.267031		67.00
68.00	06800	SPEECH PATHOLOGY	0.318358		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.598820		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.305453		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.510941		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	DIABETES	6.865773		90.01
90.02	09002	OP PSYCH	0.860728		90.02
90.03	09003	PAIN MANAGEMENT	0.370907		90.03
91.00	09100	EMERGENCY	0.325788		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.445597		92.00
93.00	04040	CARDIAC REHAB	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
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

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

Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part II Date/Time Prepared: 2/23/2016 2:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,035,583	141,604	1,893,979	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,000,556	99,906	1,900,650	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	206,892	11,239	195,653	0	0	54.03
60.00	06000	LABORATORY	2,105,367	48,115	2,057,252	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	956,690	45,730	910,960	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,350,246	81,920	1,268,326	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	431,473	22,161	409,312	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	226,184	2,337	223,847	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	376,739	91,907	284,832	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	277,506	823	276,683	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,587,084	30,442	1,556,642	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	25,362	103	25,259	0	0	90.00
90.01	09001	DIABETES	159,794	35,950	123,844	0	0	90.01
90.02	09002	OP PSYCH	159,406	5,624	153,782	0	0	90.02
90.03	09003	PAIN MANAGEMENT	264,028	892	263,136	0	0	90.03
91.00	09100	EMERGENCY	2,732,024	246,940	2,485,084	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	475,730	57,494	418,236	0	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	611,762	14,833	596,929	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	15,982,426	938,020	15,044,406	0	0	200.00
201.00		Less Observation Beds	475,730	57,494	418,236	0	0	201.00
202.00		Total (line 200 minus line 201)	15,506,696	880,526	14,626,170	0	0	202.00

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

Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part II Date/Time Prepared: 2/23/2016 2:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,035,583	5,002,736	0.406894		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,000,556	10,681,621	0.187290		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	206,892	364,954	0.566899		54.03
60.00	06000	LABORATORY	2,105,367	8,157,157	0.258101		60.00
65.00	06500	RESPIRATORY THERAPY	956,690	2,396,605	0.399186		65.00
66.00	06600	PHYSICAL THERAPY	1,350,246	4,442,039	0.303970		66.00
67.00	06700	OCCUPATIONAL THERAPY	431,473	1,615,817	0.267031		67.00
68.00	06800	SPEECH PATHOLOGY	226,184	710,471	0.318358		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	376,739	629,136	0.598820		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	277,506	908,507	0.305453		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,587,084	3,106,201	0.510941		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	25,362	0	0.000000		90.00
90.01	09001	DIABETES	159,794	23,274	6.865773		90.01
90.02	09002	OP PSYCH	159,406	185,199	0.860728		90.02
90.03	09003	PAIN MANAGEMENT	264,028	711,844	0.370907		90.03
91.00	09100	EMERGENCY	2,732,024	8,385,889	0.325788		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	475,730	329,089	1.445597		92.00
93.00	04040	CARDIAC REHAB	0	0	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	611,762	602,261	1.015776		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	15,982,426	48,252,800			200.00
201.00		Less Observation Beds	475,730	0			201.00
202.00		Total (line 200 minus line 201)	15,506,696	48,252,800			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 2/23/2016 2:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	141,604	5,002,736	0.028305	253,188	7,166	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,906	10,681,621	0.009353	166,881	1,561	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	11,239	364,954	0.030796	9,492	292	54.03
60.00	06000	LABORATORY	48,115	8,157,157	0.005899	444,102	2,620	60.00
65.00	06500	RESPIRATORY THERAPY	45,730	2,396,605	0.019081	252,040	4,809	65.00
66.00	06600	PHYSICAL THERAPY	81,920	4,442,039	0.018442	156,915	2,894	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,161	1,615,817	0.013715	47,329	649	67.00
68.00	06800	SPEECH PATHOLOGY	2,337	710,471	0.003289	14,114	46	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	91,907	629,136	0.146084	185,313	27,071	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	823	908,507	0.000906	384,679	349	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,442	3,106,201	0.009800	264,437	2,591	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	103	0	0.000000	0	0	90.00
90.01	09001	DIABETES	35,950	23,274	1.544642	0	0	90.01
90.02	09002	OP PSYCH	5,624	185,199	0.030367	0	0	90.02
90.03	09003	PAIN MANAGEMENT	892	711,844	0.001253	0	0	90.03
91.00	09100	EMERGENCY	246,940	8,385,889	0.029447	1,780	52	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	57,494	329,089	0.174707	1,855	324	92.00
93.00	04040	CARDIAC REHAB	0	0	0.000000	0	0	93.00
200.00		Total (lines 50-199)	923,187	47,650,539		2,182,125	50,424	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 2:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03
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 PATIENTS	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	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
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: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 2:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,002,736	0.000000	0.000000	253,188	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,681,621	0.000000	0.000000	166,881	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	364,954	0.000000	0.000000	9,492	54.03
60.00	06000	LABORATORY	0	8,157,157	0.000000	0.000000	444,102	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,396,605	0.000000	0.000000	252,040	65.00
66.00	06600	PHYSICAL THERAPY	0	4,442,039	0.000000	0.000000	156,915	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,615,817	0.000000	0.000000	47,329	67.00
68.00	06800	SPEECH PATHOLOGY	0	710,471	0.000000	0.000000	14,114	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	629,136	0.000000	0.000000	185,313	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	908,507	0.000000	0.000000	384,679	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,106,201	0.000000	0.000000	264,437	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	DIABETES	0	23,274	0.000000	0.000000	0	90.01
90.02	09002	OP PSYCH	0	185,199	0.000000	0.000000	0	90.02
90.03	09003	PAIN MANAGEMENT	0	711,844	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	8,385,889	0.000000	0.000000	1,780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	329,089	0.000000	0.000000	1,855	92.00
93.00	04040	CARDIAC REHAB	0	0	0.000000	0.000000	0	93.00
200.00		Total (lines 50-199)	0	47,650,539			2,182,125	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 2:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0		54.03
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 PATIENTS	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	DIABETES	0	0	0		90.01
90.02	09002	OP PSYCH	0	0	0		90.02
90.03	09003	PAIN MANAGEMENT	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	CARDIAC REHAB	0	0	0		93.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/23/2016 2:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.406894	0	1,757,871	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187290	0	2,825,517	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.566899	0	129,184	0	0	54.03
60.00	06000	LABORATORY	0.258101	0	2,799,452	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.399186	0	530,153	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.303970	0	1,233,868	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.267031	0	276,347	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.318358	0	79,947	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.598820	0	86,111	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.305453	0	150,344	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.510941	0	1,006,178	792	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	17	0	0	90.00
90.01	09001	DIABETES	6.865773	0	2,522	0	0	90.01
90.02	09002	OP PSYCH	0.860728	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.370907	0	41,584	0	0	90.03
91.00	09100	EMERGENCY	0.325788	0	1,710,127	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.445597	0	151,226	0	0	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	12,780,448	792	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	12,780,448	792	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/23/2016 2:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	715,267	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	529,191	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	73,234	0		54.03
60.00	06000	LABORATORY	722,541	0		60.00
65.00	06500	RESPIRATORY THERAPY	211,630	0		65.00
66.00	06600	PHYSICAL THERAPY	375,059	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	73,793	0		67.00
68.00	06800	SPEECH PATHOLOGY	25,452	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,565	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,923	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	514,098	405		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	DIABETES	17,315	0		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	15,424	0		90.03
91.00	09100	EMERGENCY	557,139	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	218,612	0		92.00
93.00	04040	CARDIAC REHAB	0	0		93.00
200.00		Subtotal (see instructions)	4,146,243	405		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,146,243	405		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151319 | Component CCN: 15Z319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/23/2016 2:01 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.406894	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187290	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.566899	0	0	0	0	54.03
60.00	06000	LABORATORY	0.258101	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.399186	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.303970	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.267031	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.318358	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.598820	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.305453	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.510941	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	DIABETES	6.865773	0	0	0	0	90.01
90.02	09002	OP PSYCH	0.860728	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.370907	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.325788	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.445597	0	0	0	0	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	0	0	93.00
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: 151319 | Component CCN: 15Z319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V | Date/Time Prepared: 2/23/2016 2:01 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0		54.03
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 PATIENTS	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	DIABETES	0	0		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	CARDIAC REHAB	0	0		93.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part I Date/Time Prepared: 2/23/2016 2:01 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	270,901	51,696	219,205	1,635	134.07	30.00
31.00	INTENSIVE CARE UNIT	50,991		50,991	190	268.37	31.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	321,892		270,196	1,825		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	70	9,385				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30-199)	70	9,385				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 2/23/2016 2:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	141,604	5,002,736	0.028305	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,906	10,681,621	0.009353	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	11,239	364,954	0.030796	0	0	54.03
60.00	06000	LABORATORY	48,115	8,157,157	0.005899	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	45,730	2,396,605	0.019081	0	0	65.00
66.00	06600	PHYSICAL THERAPY	81,920	4,442,039	0.018442	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,161	1,615,817	0.013715	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,337	710,471	0.003289	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	91,907	629,136	0.146084	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	823	908,507	0.000906	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,442	3,106,201	0.009800	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	103	0	0.000000	0	0	90.00
90.01	09001	DIABETES	35,950	23,274	1.544642	0	0	90.01
90.02	09002	OP PSYCH	5,624	185,199	0.030367	0	0	90.02
90.03	09003	PAIN MANAGEMENT	892	711,844	0.001253	0	0	90.03
91.00	09100	EMERGENCY	246,940	8,385,889	0.029447	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	57,494	329,089	0.174707	0	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0.000000	0	0	93.00
200.00		Total (lines 50-199)	923,187	47,650,539		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part III Date/Time Prepared: 2/23/2016 2:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,635	0.00	70	0		30.00
31.00	03100	INTENSIVE CARE UNIT	190	0.00	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	1,825		70	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 2:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03
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 PATIENTS	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	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
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: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 2:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,002,736	0.000000	0.000000	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,681,621	0.000000	0.000000	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	364,954	0.000000	0.000000	0	54.03
60.00	06000	LABORATORY	0	8,157,157	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,396,605	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,442,039	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,615,817	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	710,471	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	629,136	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	908,507	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,106,201	0.000000	0.000000	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	DIABETES	0	23,274	0.000000	0.000000	0	90.01
90.02	09002	OP PSYCH	0	185,199	0.000000	0.000000	0	90.02
90.03	09003	PAIN MANAGEMENT	0	711,844	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	8,385,889	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	329,089	0.000000	0.000000	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0.000000	0.000000	0	93.00
200.00		Total (lines 50-199)	0	47,650,539			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 2:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0		54.03
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 PATIENTS	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	DIABETES	0	0	0		90.01
90.02	09002	OP PSYCH	0	0	0		90.02
90.03	09003	PAIN MANAGEMENT	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	CARDIAC REHAB	0	0	0		93.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/23/2016 2:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.406894	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187290	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.566899	0	0	0	0	54.03
60.00	06000	LABORATORY	0.258101	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.399186	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.303970	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.267031	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.318358	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.598820	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.305453	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.510941	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	DIABETES	6.865773	0	0	0	0	90.01
90.02	09002	OP PSYCH	0.860728	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.370907	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.325788	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.445597	0	0	0	0	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	0	0	93.00
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: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/23/2016 2:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0		54.03
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 PATIENTS	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	DIABETES	0	0		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	CARDIAC REHAB	0	0		93.00
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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 2:01 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,077	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,635	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,288	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	377	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	65	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)	863	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)	377	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	181.25	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	181.25	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,770,199	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	11,781	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)	528,640	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,241,559	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,241,559	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)	1,370.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,183,156	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,183,156	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 2:01 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	395,179	190	2,079.89	131	272,466	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)	786,563	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,242,185	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)	516,859	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)	516,859	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)	347	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,370.98	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	475,730	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 2:01 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	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	270,901	2,241,559	0.120854	475,730	57,494	90.00
91.00	Nursing School cost	0	2,241,559	0.000000	475,730	0	91.00
92.00	Allied health cost	0	2,241,559	0.000000	475,730	0	92.00
93.00	All other Medical Education	0	2,241,559	0.000000	475,730	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 2:01 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,077	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,635	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,288	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	194	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)	183	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	29	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)	36	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	70	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	29	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)	36	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	181.25	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	181.25	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,770,199	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	5,256	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)	6,525	25.00
26.00	Total swing-bed cost (see instructions)	528,640	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,241,559	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,241,559	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)	1,370.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	95,969	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)	95,969	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 2:01 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	395,179	190	2,079.89	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	95,969	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)	9,385	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)	9,385	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	86,584	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)	5,256	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)	6,525	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	11,781	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)	347	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,370.98	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	475,730	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 2:01 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	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	270,901	2,241,559	0.120854	475,730	57,494	90.00
91.00	Nursing School cost	0	2,241,559	0.000000	475,730	0	91.00
92.00	Allied health cost	0	2,241,559	0.000000	475,730	0	92.00
93.00	All other Medical Education	0	2,241,559	0.000000	475,730	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/23/2016 2:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		719,303		30.00
31.00	03100	INTENSIVE CARE UNIT		160,551		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.406894	253,188	103,021	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187290	166,881	31,255	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.566899	9,492	5,381	54.03
60.00	06000	LABORATORY	0.258101	444,102	114,623	60.00
65.00	06500	RESPIRATORY THERAPY	0.399186	252,040	100,611	65.00
66.00	06600	PHYSICAL THERAPY	0.303970	156,915	47,697	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.267031	47,329	12,638	67.00
68.00	06800	SPEECH PATHOLOGY	0.318358	14,114	4,493	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.598820	185,313	110,969	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.305453	384,679	117,501	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.510941	264,437	135,112	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	DIABETES	6.865773	0	0	90.01
90.02	09002	OP PSYCH	0.860728	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.370907	0	0	90.03
91.00	09100	EMERGENCY	0.325788	1,780	580	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.445597	1,855	2,682	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		2,182,125	786,563	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)		2,182,125		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151319 | Component CCN: 15Z319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/23/2016 2:01 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.406894	4,008	1,631	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187290	15,891	2,976	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.566899	0	0	54.03
60.00	06000	LABORATORY	0.258101	97,667	25,208	60.00
65.00	06500	RESPIRATORY THERAPY	0.399186	32,371	12,922	65.00
66.00	06600	PHYSICAL THERAPY	0.303970	118,402	35,991	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.267031	38,528	10,288	67.00
68.00	06800	SPEECH PATHOLOGY	0.318358	8,053	2,564	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.598820	28,009	16,772	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.305453	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.510941	64,773	33,095	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	DIABETES	6.865773	0	0	90.01
90.02	09002	OP PSYCH	0.860728	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.370907	0	0	90.03
91.00	09100	EMERGENCY	0.325788	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.445597	0	0	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		407,702	141,447	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)		407,702		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/23/2016 2:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.406894	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187290	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.566899	0	0	54.03
60.00	06000	LABORATORY	0.258101	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.399186	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.303970	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.267031	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.318358	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.598820	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.305453	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.510941	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	DIABETES	6.865773	0	0	90.01
90.02	09002	OP PSYCH	0.860728	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.370907	0	0	90.03
91.00	09100	EMERGENCY	0.325788	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.445597	0	0	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	93.00
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: 151319	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/23/2016 2:01 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,146,648	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)	4,146,648	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)	4,188,114	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)	43,408	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,996,226	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,148,480	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,148,480	30.00
31.00	Primary payer payments	1,252	31.00
32.00	Subtotal (line 30 minus line 31)	2,147,228	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)	328,644	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	213,619	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	290,068	36.00
37.00	Subtotal (see instructions)	2,360,847	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)	2,360,847	40.00
40.01	Sequestration adjustment (see instructions)	47,217	40.01
41.00	Interim payments	2,542,641	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-229,011	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/23/2016 2:01 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,859,085		2,542,641	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,859,085		2,542,641	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		128,151		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		229,011	6.02
7.00	Total Medicare program liability (see instructions)		1,987,236		2,313,630	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: 151319 | Component CCN: 15Z319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/23/2016 2:01 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		544,243		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)		544,243		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		101,664		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		645,907		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: 151319	Period: From 10/01/2014 To 09/30/2015	Worksheet E-1 Part II Date/Time Prepared: 2/23/2016 2:01 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	433	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	994	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	23	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,478	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	50,039,330	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	753,506	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: 151319 Component CCN: 15Z319	Period: From 10/01/2014 To 09/30/2015	Worksheet E-2 Date/Time Prepared: 2/23/2016 2:01 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	522,028	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)	142,861	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	377	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)	664,889	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	664,889	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)	664,889	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,800	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)	659,089	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)	659,089	0	19.00
19.01	Sequestration adjustment (see instructions)	13,182	0	19.01
20.00	Interim payments	544,243	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)	101,664	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151319	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part V Date/Time Prepared: 2/23/2016 2:01 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,242,185	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,242,185	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,264,607	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,264,607	19.00
20.00	Deductibles (exclude professional component)	264,495	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,000,112	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,000,112	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	42,584	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	27,680	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	37,984	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,027,792	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	2,027,792	30.00
30.01	Sequestration adjustment (see instructions)	40,556	30.01
31.00	Interim payments	1,859,085	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)	128,151	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151319	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part VII Date/Time Prepared: 2/23/2016 2:01 pm
	Title XIX	Hospital	PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G | Date/Time Prepared: 2/23/2016 2:01 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	277,238	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,702,809	0	0	0	4.00
5.00	Other receivable	202,973	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,468,086	0	0	0	6.00
7.00	Inventory	816,213	0	0	0	7.00
8.00	Prepaid expenses	174,946	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,706,093	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	33,880,135	0	0	0	15.00
16.00	Accumulated depreciation	-22,253,935	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,626,200	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	4,762,886	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,762,886	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	22,095,179	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	858,394	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,481,616	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	901,132	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	-80,705	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,160,437	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,445,524	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	8,445,524	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	11,605,961	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	10,489,218				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)	10,489,218	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	22,095,179	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-1 | Date/Time Prepared: 2/23/2016 2:01 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		11,179,529		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-690,311				2.00
3.00	Total (sum of line 1 and line 2)		10,489,218		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		10,489,218		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)		10,489,218		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	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: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/23/2016 2:01 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,851,996		1,851,996	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	0		0	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)	1,851,996		1,851,996	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	265,004		265,004	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)	265,004		265,004	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,117,000		2,117,000	17.00
18.00	Ancillary services	4,793,172	42,317,303	47,110,475	18.00
19.00	Outpatient services	0	208,473	208,473	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		602,261	602,261	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	MOB AND SNF	2,522,659	1,043,004	3,565,663	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,432,831	44,171,041	53,603,872	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		32,010,394		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	NON OPERATING EXPENSE	3,386,314			37.00
38.00	INDUSTRIAL MEDICINE EXPENSE	3,231,521			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)		6,617,835		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		25,392,559		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-3 | Date/Time Prepared: 2/23/2016 2:01 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	53,603,872	1.00
2.00	Less contractual allowances and discounts on patients' accounts	27,535,546	2.00
3.00	Net patient revenues (line 1 minus line 2)	26,068,326	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,392,559	4.00
5.00	Net income from service to patients (line 3 minus line 4)	675,767	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	460,152	24.00
24.01	NET INDUSTRIAL MEDICINE	286,518	24.01
25.00	Total other income (sum of lines 6-24)	746,670	25.00
26.00	Total (line 5 plus line 25)	1,422,437	26.00
27.00	NET NON OPERATING REVENUE	2,099,901	27.00
27.01	NON OPERATING INCOME	12,847	27.01
27.02		0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	2,112,748	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-690,311	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151319 | HHA CCN: 157445 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H | Date/Time Prepared: 2/23/2016 2:01 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	81,958	24,663	32,623	0	27,068	166,312	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	174,550	52,527	0	0	0	227,077	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	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	51,761	15,576	0	0	0	67,337	11.00
12.00	Supplies (see instructions)	0	0	0	0	806	806	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	308,269	92,766	32,623	0	27,874	461,532	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	-6,203	160,109	0	160,109			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	227,077	0	227,077			6.00
7.00	Physical Therapy	0	0	0	0			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	67,337	0	67,337			11.00
12.00	Supplies (see instructions)	0	806	0	806			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	-6,203	455,329	0	455,329			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: 151319 | HHA CCN: 157445 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-1 Part I | Date/Time Prepared: 2/23/2016 2:01 pm

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	160,109	0	0	0	0	160,109	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	227,077	0	0	0	0	227,077	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	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	67,337	0	0	0	0	67,337	11.00
12.00	Supplies (see instructions)	806	0	0	0	0	806	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	455,329	0	0	0	0	455,329	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	160,109			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	123,153	350,230		6.00
7.00	Physical Therapy	0	0		7.00
8.00	Occupational Therapy	0	0		8.00
9.00	Speech Pathology	0	0		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Home Health Aide	36,519	103,856		11.00
12.00	Supplies (see instructions)	437	1,243		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
24.00	Total (sum of lines 1-23)		455,329		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 151319 HHA CCN: 157445 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-1 Part II Date/Time Prepared: 2/23/2016 2:01 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-160,109	295,220	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	227,077	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	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	67,337	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	806	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-160,109	295,220	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		160,109	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.542338	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151319 HHA CCN: 157445 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-2 Part I Date/Time Prepared: 2/23/2016 2:01 pm

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	4,602	5,461	29,584	39,647	7,877	1.00
2.00	Skilled Nursing Care	350,230	0	0	0	350,230	69,587	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	103,856	0	0	0	103,856	20,635	7.00
8.00	Supplies (see instructions)	1,243	0	0	0	1,243	247	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	455,329	4,602	5,461	29,584	494,976	98,346	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	13,647	0	4,793	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	13,647	0	4,793	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-2 Part I | Date/Time Prepared: 2/23/2016 2:01 pm

HHA CCN: 157445 | Home Health Agency I | PPS

	Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		16.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	65,964	0	65,964			1.00
2.00	Skilled Nursing Care	0	419,817	0	419,817	50,738	470,555	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	124,491	0	124,491	15,046	139,537	7.00
8.00	Supplies (see instructions)	0	1,490	0	1,490	180	1,670	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	611,762	0	611,762	65,964	611,762	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.					0.120858		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: 151319 HHA CCN: 157445 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-2 Part II Date/Time Prepared: 2/23/2016 2:01 pm

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	505	505	308,269	0	39,647	505	1.00
2.00	Skilled Nursing Care	0	0	0	0	350,230	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	103,856	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	1,243	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	505	505	308,269		494,976	505	20.00
21.00	Total cost to be allocated	4,602	5,461	29,584		98,346	13,647	21.00
22.00	Unit cost multiplier	9.112871	10.813861	0.095968		0.198688	27.023762	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (NRSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		8.00	9.00	10.00	11.00	13.00	16.00	
1.00	Administrative and General	0	505	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	505	0	0	0	0	20.00
21.00	Total cost to be allocated	0	4,793	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	9.491089	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151319 | HHA CCN: 157445 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-3 Part I | Date/Time Prepared: 2/23/2016 2:01 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	470,555		470,555	2,361	199.30	1.00
2.00	Physical Therapy	3.00	0	0	0	1,366	0.00	2.00
3.00	Occupational Therapy	4.00	0	0	0	349	0.00	3.00
4.00	Speech Pathology	5.00	0	0	0	30	0.00	4.00
5.00	Medical Social Services	6.00	0		0	11	0.00	5.00
6.00	Home Health Aide	7.00	139,537		139,537	766	182.16	6.00
7.00	Total (sum of lines 1-6)		610,092	0	610,092	4,883		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		21780	0	1,337			8.00
9.00	Physical Therapy		21780	0	980			9.00
10.00	Occupational Therapy		21780	0	194			10.00
11.00	Speech Pathology		21780	0	16			11.00
12.00	Medical Social Services		21780	0	7			12.00
13.00	Home Health Aide		21780	0	530			13.00
14.00	Total (sum of lines 8-13)			0	3,064			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 Record)	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	1,670	0	1,670	3,986	0.418966	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	1,337		0	266,464		1.00
2.00	Physical Therapy	0	980		0	0		2.00
3.00	Occupational Therapy	0	194		0	0		3.00
4.00	Speech Pathology	0	16		0	0		4.00
5.00	Medical Social Services	0	7		0	0		5.00
6.00	Home Health Aide	0	530		0	96,545		6.00
7.00	Total (sum of lines 1-6)	0	3,064		0	363,009		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 151319 HHA CCN: 157445 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-3 Part I Date/Time Prepared: 2/23/2016 2:01 pm

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	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	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	266,464	1.00
2.00	Physical Therapy	0	2.00
3.00	Occupational Therapy	0	3.00
4.00	Speech Pathology	0	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	96,545	6.00
7.00	Total (sum of lines 1-6)	363,009	7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151319 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-3 Part II | Date/Time Prepared: 2/23/2016 2:01 pm

HHA CCN: 157445 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.303970	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.267031	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.318358	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.598820	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.510941	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 151319 | HHA CCN: 157445 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/23/2016 2:01 pm

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	377,794	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	8,557	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	5,260	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	1,164	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	1,010	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	393,785	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	393,785	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	393,785	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	393,785	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	393,785	31.00
31.01	Sequestration adjustment (see instructions)	0	7,876	31.01
32.00	Interim payments (see instructions)	0	385,910	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	-1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 151319 HHA CCN: 157445 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-5 | Date/Time Prepared: 2/23/2016 2:01 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		385,910	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		385,910	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		1	6.02
7.00	Total Medicare program liability (see instructions)		0		385,909	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00