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: 151329	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/26/2016 11:50 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/26/2016 Time: 11:50 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARGARET MARY COMMUNITY HOSPITAL (151329) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	659,071	-595,319	395,678	138,721	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		74,058		0	10.00
200.00	Total	0	659,071	-521,260	395,678	138,721	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: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2016 11:49 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 321 MITCHELL	PO Box:			1.00
2.00	City: BATESVILLE	State: IN	Zip Code: 47006-	County: RIPLEY	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	MARGARET MARY COMMUNITY HOSPITAL	151329	99915	1	01/07/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									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	MARGARET MARY COMMUNITY HOSPITAL	157143	99915		03/01/1985	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	MARGARET MARY COMMUNITY HOSPITAL	151551	99915		12/31/2003				14.00
15.00	Hospital-Based Health Clinic - RHC	MARGARET MARY COMMUNITY HOSPITAL	158511	99915		09/03/2013	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2015	12/31/2015	20.00
21.00	Type of Control (see instructions)	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		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.	0		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2016 11:49 am

		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	
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

		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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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

		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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2016 11:49 am

		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

		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

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		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
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.	1			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

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		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
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151329	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 11:49 am

							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)						548,279	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)					01/01/2015	12/31/2015	170.00
							1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)						N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2016 11:49 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N			3.00
			Y/N	Type	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A		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	02/03/2016	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: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2016 11:49 am

		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.				Y	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957	KCSMITH@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2016 11:49 am

		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)	02/03/2016			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.		SENIOR MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/26/2016 11:49 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	18	6,570	104,808.00	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)		18	6,570	104,808.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,555	8,640.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	113,448.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						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: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2016 11:49 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,914	139	4,367			1.00
2.00	HMO and other (see instructions)	378	595				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,914	139	4,367			7.00
8.00	INTENSIVE CARE UNIT	205	3	360			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	928			13.00
14.00	Total (see instructions)	2,119	142	5,655	0.00	448.75	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	5,380	812	9,013	0.00	18.53	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	12.03	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,277	1,058	4,109	0.00	5.94	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	485.25	27.00
28.00	Observation Bed Days		11	942			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: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2016 11:49 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	661	51	1,661	1.00
2.00	HMO and other (see instructions)			119	257		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	661	51	1,661	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 151329 | Component CCN: 157143 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-4 | Date/Time Prepared: 5/26/2016 11:49 am

Home Health Agency I | PPS

					1.00		
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	307.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			6.24	0.00	6.24	5.00
6.00	Direct Nursing Service			6.65	0.00	6.65	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			3.59	0.00	3.59	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.63	0.00	0.63	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.02	0.00	0.02	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.20	0.00	0.20	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.20	0.00	1.20	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.			6			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			17140			20.00
20.01				50031			20.01
20.02				50034			20.02
20.03				50035			20.03
20.04				50042			20.04
20.05				99915			20.05
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	2,744	28	94	49	2,915	21.00
22.00	Skilled Nursing Visit Charges	459,984	4,704	15,120	8,232	488,040	22.00
23.00	Physical Therapy Visits	1,646	7	16	22	1,691	23.00
24.00	Physical Therapy Visit Charges	332,492	1,414	3,232	4,444	341,582	24.00
25.00	Occupational Therapy Visits	329	7	1	10	347	25.00
26.00	Occupational Therapy Visit Charges	71,064	1,512	216	2,160	74,952	26.00
27.00	Speech Pathology Visits	32	0	2	12	46	27.00
28.00	Speech Pathology Visit Charges	6,976	0	436	2,616	10,028	28.00
29.00	Medical Social Service Visits	13	0	0	0	13	29.00
30.00	Medical Social Service Visit Charges	4,160	0	0	0	4,160	30.00
31.00	Home Health Aide Visits	353	15	0	0	368	31.00
32.00	Home Health Aide Visit Charges	34,947	1,485	0	0	36,432	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,117	57	113	93	5,380	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)	909,623	9,115	19,004	17,452	955,194	35.00
36.00	Total Number of Episodes (standard/non outlier)	333		43	6	382	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	74,145	2,204	182	6	76,537	38.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 151329 | Component CCN: 158511 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-8 | Date/Time Prepared: 5/26/2016 11:49 am

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	112 N. BUCKEYE ST.	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	OSGOOD	IN	47037	2.00

		1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	16:30	08:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County						2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 151329 Component CCN: 158511	Period: From 01/01/2015 To 12/31/2015	Worksheet S-8 Date/Time Prepared: 5/26/2016 11:49 am
		Rural Health Clinic (RHC) I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	12:00				11.00

HOSPITAL IDENTIFICATION DATA	Provider CCN: 151329 Component CCN: 151551	Period: From 01/01/2015 To 12/31/2015	Worksheet S-9 Parts I & II Date/Time Prepared: 5/26/2016 11:49 am
		Hospice I	

		Unduplicated Days Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	10,943	84	5,507	0	797	11,824	2.00
3.00	Inpatient Respite Care	0	0	0	0	0	0	3.00
4.00	General Inpatient Care	6	0	0	0	2	8	4.00
5.00	Total Hospice Days	10,949	84	5,507	0	799	11,832	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	116	7	87	0	107	230	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	94.39	12.00	63.30	0.00	7.47	51.44	8.00
9.00	Unduplicated Census Count	190	7	85	0	22	219	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-10 | Date/Time Prepared: 5/26/2016 11:49 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.373224	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,103,027	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	7,809,678	6.00
7.00	Medicaid cost (line 1 times line 6)	2,914,759	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)	811,732	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)	811,732	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	2,311,419	0	2,311,419	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	862,677	0	862,677	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	862,677	0	862,677	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)	7,083,404	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	702,039	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	6,381,365	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,381,679	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,244,356	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,056,088	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/26/2016 11:49 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		3,086,052	3,086,052	-10,990	3,075,062	1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG		599,837	599,837	10,990	610,827	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		4,078,222	4,078,222	-158,573	3,919,649	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0	0	158,573	158,573	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	177,343	11,934,377	12,111,720	0	12,111,720	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,883,185	6,241,050	11,124,235	222,847	11,347,082	5.00
7.00	00700	OPERATION OF PLANT	0	1,300,769	1,300,769	-171	1,300,598	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	107,129	107,129	0	107,129	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	489,625	9,078	498,703	0	498,703	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	82,256	63,268	145,524	-12,710	132,814	8.00
9.00	00900	HOUSEKEEPING	640,496	259,637	900,133	0	900,133	9.00
10.00	01000	DIETARY	785,023	521,297	1,306,320	-1,133,448	172,872	10.00
11.00	01100	CAFETERIA	0	0	0	1,098,301	1,098,301	11.00
13.00	01300	NURSING ADMINISTRATION	698,209	14,638	712,847	-2	712,845	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	425,932	425,932	-425,825	107	14.00
15.00	01500	PHARMACY	566,420	2,335,499	2,901,919	-1,227	2,900,692	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	888,657	154,289	1,042,946	-1,709	1,041,237	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,598,604	145,249	1,743,853	434,104	2,177,957	30.00
31.00	03100	INTENSIVE CARE UNIT	362,382	15,470	377,852	-8,090	369,762	31.00
43.00	04300	NURSERY	0	103,248	103,248	566,187	669,435	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,329,180	3,171,436	4,500,616	-2,873,669	1,626,947	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,066,775	213,263	1,280,038	-1,172,989	107,049	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,650,194	5,607,665	8,257,859	-188,912	8,068,947	54.00
60.00	06000	LABORATORY	1,229,700	1,980,097	3,209,797	-40,527	3,169,270	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	439,596	98,471	538,067	-12,182	525,885	65.00
66.00	06600	PHYSICAL THERAPY	967,266	78,354	1,045,620	-14,907	1,030,713	66.00
67.00	06700	OCCUPATIONAL THERAPY	333,664	21,139	354,803	-10,915	343,888	67.00
68.00	06800	SPEECH PATHOLOGY	187,220	1,485	188,705	-10,552	178,153	68.00
69.00	06900	ELECTROCARDIOLOGY	532,650	336,324	868,974	-14,418	854,556	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,619,735	2,619,735	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,650,682	1,650,682	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	503,716	76,240	579,956	0	579,956	88.00
90.00	09000	CLINIC	1,428,581	294,160	1,722,741	-197,794	1,524,947	90.00
90.01	09001	WOUND CLINC	225,595	159,619	385,214	-150,824	234,390	90.01
91.00	09100	EMERGENCY	1,554,112	2,221,805	3,775,917	-102,501	3,673,416	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,262,287	183,596	1,445,883	0	1,445,883	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	634,181	352,108	986,289	0	986,289	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	25,516,917	46,190,803	71,707,720	218,484	71,926,204	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,533,468	1,555,837	9,089,305	0	9,089,305	192.00
192.01	19201	PRIVATE DUTY	0	0	0	0	0	192.01
194.00	07950	COMMUNITY RELATIONS	194,843	499,102	693,945	-228,078	465,867	194.00
194.01	07951	COMMUNITY BENEFITS	336,424	115,426	451,850	0	451,850	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	9,594	9,594	194.02
194.03	07953	EMS	13,361	43,130	56,491	0	56,491	194.03
200.00		TOTAL (SUM OF LINES 118-199)	33,595,013	48,404,298	81,999,311	0	81,999,311	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/26/2016 11:49 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-947,083	2,127,979		1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	0	610,827		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-302,918	3,616,731		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	158,573		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,111,720		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,659,517	9,687,565		5.00
7.00	00700	OPERATION OF PLANT	-5,620	1,294,978		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	107,129		7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	498,703		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	-555	132,259		8.00
9.00	00900	HOUSEKEEPING	0	900,133		9.00
10.00	01000	DIETARY	-21,273	151,599		10.00
11.00	01100	CAFETERIA	-303,217	795,084		11.00
13.00	01300	NURSING ADMINISTRATION	0	712,845		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	107		14.00
15.00	01500	PHARMACY	0	2,900,692		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,361	1,035,876		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-146,811	2,031,146		30.00
31.00	03100	INTENSIVE CARE UNIT	0	369,762		31.00
43.00	04300	NURSERY	-102,337	567,098		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,626,947		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	107,049		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-822,324	7,246,623		54.00
60.00	06000	LABORATORY	0	3,169,270		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	525,885		65.00
66.00	06600	PHYSICAL THERAPY	-14,699	1,016,014		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	343,888		67.00
68.00	06800	SPEECH PATHOLOGY	0	178,153		68.00
69.00	06900	ELECTROCARDIOLOGY	-179,245	675,311		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,619,735		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,650,682		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	579,956		88.00
90.00	09000	CLINIC	-462,399	1,062,548		90.00
90.01	09001	WOUND CLINC	0	234,390		90.01
91.00	09100	EMERGENCY	-1,687,161	1,986,255		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	1,445,883		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	986,289		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,660,520	65,265,684		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,089,305		192.00
192.01	19201	PRIVATE DUTY	0	0		192.01
194.00	07950	COMMUNITY RELATIONS	0	465,867		194.00
194.01	07951	COMMUNITY BENEFITS	0	451,850		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	9,594		194.02
194.03	07953	EMS	0	56,491		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-6,660,520	75,338,791		200.00

RECLASSIFICATIONS | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/26/2016 11:49 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	660,018	438,283		1.00
	0		660,018	438,283		
	B - OB RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	468,255	58,455		1.00
2.00	NURSERY	43.00	503,351	62,836		2.00
	0		971,606	121,291		
	C - COMMUNITY RELATIONS					
1.00	ADMINISTRATIVE & GENERAL	5.00	68,195	159,883		1.00
	0		68,195	159,883		
	D - OFFSITE BUILDING DEPR RECLASS					
1.00	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	10,990		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	158,573		2.00
	0		0	169,563		
	E - IMPLANTABLE SUPPLIES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,650,682		1.00
	0		0	1,650,682		
	F - SPEECH RECLASS					
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.02	9,567	27		1.00
	0		9,567	27		
	I - CENTRAL SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,619,735		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
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
	TOTALS		0	2,619,735		
500.00	Grand Total: Increases		1,709,386	5,159,464		500.00

RECLASSIFICATIONS | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/26/2016 11:49 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA					
1.00	DIETARY	10.00	660,018	438,283	0	1.00
	0		660,018	438,283		
	B - OB RECLASS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	971,606	121,291	0	1.00
2.00		0.00	0	0	0	2.00
	0		971,606	121,291		
	C - COMMUNITY RELATIONS					
1.00	COMMUNITY RELATIONS	194.00	68,195	159,883	0	1.00
	0		68,195	159,883		
	D - OFFSITE BUILDING DEPR RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	10,990	9	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	158,573	9	2.00
	0		0	169,563		
	E - IMPLANTABLE SUPPLIES RECLASS					
1.00	OPERATING ROOM	50.00	0	1,650,682	0	1.00
	0		0	1,650,682		
	F - SPEECH RECLASS					
1.00	SPEECH PATHOLOGY	68.00	9,567	27	0	1.00
	0		9,567	27		
	I - CENTRAL SUPPLY RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,231	0	1.00
2.00	OPERATION OF PLANT	7.00	0	171	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	12,710	0	3.00
4.00	DIETARY	10.00	0	35,147	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	2	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	425,825	0	6.00
7.00	PHARMACY	15.00	0	1,227	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,709	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	92,606	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	8,090	0	10.00
11.00	OPERATING ROOM	50.00	0	1,222,987	0	11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	80,092	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	188,912	0	13.00
14.00	LABORATORY	60.00	0	40,527	0	14.00
15.00	RESPIRATORY THERAPY	65.00	0	12,182	0	15.00
16.00	PHYSICAL THERAPY	66.00	0	14,907	0	16.00
17.00	OCCUPATIONAL THERAPY	67.00	0	10,915	0	17.00
18.00	SPEECH PATHOLOGY	68.00	0	958	0	18.00
19.00	ELECTROCARDIOLOGY	69.00	0	14,418	0	19.00
20.00	CLINIC	90.00	0	197,794	0	20.00
21.00	WOUND CLINC	90.01	0	150,824	0	21.00
22.00	EMERGENCY	91.00	0	102,501	0	22.00
	TOTALS		0	2,619,735		
500.00	Grand Total: Decreases		1,709,386	5,159,464		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2016 11:49 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,371,158	0	0	0	0	1.00
2.00	Land Improvements	398,310	25,591	0	25,591	0	2.00
3.00	Buildings and Fixtures	68,968,816	855,062	0	855,062	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	6,341,285	0	0	0	0	5.00
6.00	Movable Equipment	41,727,166	7,785,342	0	7,785,342	2,229,542	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	119,806,735	8,665,995	0	8,665,995	2,229,542	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	119,806,735	8,665,995	0	8,665,995	2,229,542	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,371,158	0	1.00
2.00	Land Improvements	423,901	0	2.00
3.00	Buildings and Fixtures	69,823,878	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	6,341,285	0	5.00
6.00	Movable Equipment	47,282,966	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	126,243,188	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	126,243,188	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/26/2016 11:49 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,926,316	0	1,159,736	0	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	599,837	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4,078,222	0	0	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	6,604,375	0	1,159,736	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	3,086,052		1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	599,837		1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	4,078,222		2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0		2.01
3.00	Total (sum of lines 1-2)	0	7,764,111		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/26/2016 11:49 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: 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	59,356,695	0	59,356,695	0.470178	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	13,262,242	0	13,262,242	0.105053	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	53,624,251	0	53,624,251	0.424769	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	126,243,188	0	126,243,188	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,915,326	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	610,827	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	3,616,731	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	158,573	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	6,301,457	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	212,653	0	0	0	2,127,979	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	0	610,827	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,616,731	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	158,573	2.01
3.00	Total (sum of lines 1-2)	212,653	0	0	0	6,514,110	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/26/2016 11:49 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-OFFSITE BLDG (chapter 2)		0	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,395,220			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		0		0.00	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		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-OFFSITE BLDG		0	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/26/2016 11:49 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	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	-302,918	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHEROPERATING GIRLS ON THE RUN REVE	B	-25,812	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	OTHEROPERATING OTHOP - INTERNAL SALE	B	-2,246	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	MMCH OTHER OPERATING COMMBENEFITS SC	B	-20,536	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	OTHEROPERATING DIABETES PROGRAM	B	-30,306	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	OTHEROPERATING OTHOP-COMMUNITY CLASS	B	-7,899	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	OTHEROPERATING OTHOP-PURCHASE DISCOU	B	-2,547	ADMINISTRATIVE & GENERAL	5.00	0	38.00
40.00	NON-OPERATING R OTHOP-MISC REVENUE	B	-2,896	OPERATION OF PLANT	7.00	0	40.00
41.00	OTHEROPERATING OTHOP-LAUNDRY SERVICE	B	-555	LAUNDRY & LINEN SERVICE	8.00	0	41.00
43.00	OTHEROPERATING OTHOP-VENDING SALES	B	-3,461	DIETARY	10.00	0	43.00
44.00	OTHEROPERATING OTHOP-DIET SUPP/INS	B	-17,812	DIETARY	10.00	0	44.00
45.00	CAFETERIA OFFSET	B	-303,051	CAFETERIA	11.00	0	45.00
45.01	NON-OPERATING OTHOP-CAFE SALES	B	-166	CAFETERIA	11.00	0	45.01
45.02	OTHEROPERATING OTHOP-MEDRED TRANSC	B	-5,361	MEDICAL RECORDS & LIBRARY	16.00	0	45.02
45.03	OTHEROPERATING OTHOP-PHYSICAL THERAP	B	-14,699	PHYSICAL THERAPY	66.00	0	45.03
45.04	INTEREST OFFSET	A	-947,083	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	45.04
45.05	TV OFFSET	A	-2,724	OPERATION OF PLANT	7.00	0	45.05
45.06	LOBBYING EXPENSE	A	-4,465	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07	MEDICAL STAFF RETENTION COST	A	-241,254	ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08	MEDICAL STAFF PLACEMENT FEE	A	-267,705	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09	HAF	A	-1,056,747	ADMINISTRATIVE & GENERAL	5.00	0	45.09
45.10	BOUTIQUE OFFSET	A	-5,057	RADIOLOGY-DIAGNOSTIC	54.00	0	45.10
45.11			0		0.00	0	45.11
45.12			0		0.00	0	45.12
45.13			0		0.00	0	45.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,660,520				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: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2016 11:49 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	175,144	146,811	28,333	0	0	1.00
2.00	43.00	NURSERY	102,337	102,337	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	236,030	212,030	24,000	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	529,241	529,241	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	109,996	75,996	34,000	0	0	5.00
6.00	60.00	LABORATORY	77,520	0	77,520	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	179,245	179,245	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	27,996	0	27,996	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	9,996	0	9,996	0	0	9.00
10.00	90.00	CLINIC	462,399	462,399	0	0	0	10.00
11.00	91.00	EMERGENCY	28,887	24,984	3,903	0	0	11.00
12.00	91.00	EMERGENCY	1,972,095	1,562,294	409,801	0	0	12.00
13.00	91.00	EMERGENCY	99,883	99,883	0	0	0	13.00
200.00			4,010,769	3,395,220	615,549		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	43.00	NURSERY	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	9.00
10.00	90.00	CLINIC	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	0	0	0	0	0	12.00
13.00	91.00	EMERGENCY	0	0	0	0	0	13.00
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	146,811		1.00
2.00	43.00	NURSERY	0	0	0	102,337		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	212,030		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	529,241		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	75,996		5.00
6.00	60.00	LABORATORY	0	0	0	0		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	179,245		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0		9.00
10.00	90.00	CLINIC	0	0	0	462,399		10.00
11.00	91.00	EMERGENCY	0	0	0	24,984		11.00
12.00	91.00	EMERGENCY	0	0	0	1,562,294		12.00
13.00	91.00	EMERGENCY	0	0	0	99,883		13.00
200.00			0	0	0	3,395,220		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/26/2016 11:49 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,127,979	2,127,979				1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	610,827	0	610,827			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	3,616,731			3,616,731		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	158,573			0	158,573	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,111,720	10,940	0	18,593	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,687,565	260,018	0	441,928	0	5.00
7.00	00700	OPERATION OF PLANT	1,294,978	486,824	0	827,408	0	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	107,129	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	498,703	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	132,259	26,784	0	45,523	0	8.00
9.00	00900	HOUSEKEEPING	900,133	28,691	0	48,763	0	9.00
10.00	01000	DIETARY	151,599	12,925	0	21,968	0	10.00
11.00	01100	CAFETERIA	795,084	68,233	0	115,970	0	11.00
13.00	01300	NURSING ADMINISTRATION	712,845	6,065	0	10,307	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	107	0	0	0	0	14.00
15.00	01500	PHARMACY	2,900,692	8,148	0	13,849	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,035,876	35,709	0	60,691	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,031,146	182,535	0	310,238	0	30.00
31.00	03100	INTENSIVE CARE UNIT	369,762	17,722	0	30,120	0	31.00
43.00	04300	NURSERY	567,098	9,033	0	15,352	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,626,947	46,383	0	78,833	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	107,049	16,021	0	27,230	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,246,623	197,947	0	336,433	0	54.00
60.00	06000	LABORATORY	3,169,270	49,371	0	83,912	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	525,885	40,496	0	68,827	0	65.00
66.00	06600	PHYSICAL THERAPY	1,016,014	48,064	0	81,690	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	343,888	12,797	0	21,751	0	67.00
68.00	06800	SPEECH PATHOLOGY	178,153	6,949	0	11,811	0	68.00
69.00	06900	ELECTROCARDIOLOGY	675,311	27,679	0	47,043	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,619,735	10,153	0	17,257	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,650,682	49,116	0	83,478	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	579,956	0	47,410	0	12,308	88.00
90.00	09000	CLINIC	1,062,548	101,652	0	172,769	0	90.00
90.01	09001	WOUND CLINC	234,390	6,074	0	10,324	0	90.01
91.00	09100	EMERGENCY	1,986,255	122,372	0	207,984	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,445,883	33,566	0	57,049	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	986,289	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	65,265,684	1,922,267	47,410	3,267,101	12,308	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,089,305	184,835	563,417	314,148	146,265	192.00
192.01	19201	PRIVATE DUTY	0	0	0	0	0	192.01
194.00	07950	COMMUNITY RELATIONS	465,867	2,487	0	4,226	0	194.00
194.01	07951	COMMUNITY BENEFITS	451,850	18,390	0	31,256	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	9,594	0	0	0	0	194.02
194.03	07953	EMS	56,491	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	75,338,791	2,127,979	610,827	3,616,731	158,573	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/26/2016 11:49 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
			4.00	4A	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,141,253					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,798,925	12,188,436	12,188,436			5.00
7.00	00700	OPERATION OF PLANT	0	2,609,210	503,596	3,112,806		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	107,129	20,677	0	127,806	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	177,890	676,593	130,587	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	29,885	234,451	45,251	60,848	0	8.00
9.00	00900	HOUSEKEEPING	232,704	1,210,291	233,595	65,180	0	9.00
10.00	01000	DIETARY	45,417	231,909	44,760	29,363	0	10.00
11.00	01100	CAFETERIA	239,796	1,219,083	235,292	155,012	0	11.00
13.00	01300	NURSING ADMINISTRATION	253,672	982,889	189,704	13,777	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	107	21	0	0	14.00
15.00	01500	PHARMACY	205,791	3,128,480	603,819	18,511	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	322,865	1,455,141	280,852	81,123	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	750,927	3,274,846	632,068	414,682	0	30.00
31.00	03100	INTENSIVE CARE UNIT	131,660	549,264	106,012	40,260	0	31.00
43.00	04300	NURSERY	182,876	774,359	149,457	20,521	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	482,915	2,235,078	431,386	105,373	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,577	184,877	35,683	36,397	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	962,863	8,743,866	1,687,627	449,697	0	54.00
60.00	06000	LABORATORY	446,772	3,749,325	723,646	112,161	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	159,713	794,921	153,425	91,998	0	65.00
66.00	06600	PHYSICAL THERAPY	351,425	1,497,193	288,969	109,191	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	121,226	499,662	96,438	29,073	0	67.00
68.00	06800	SPEECH PATHOLOGY	64,545	261,458	50,463	15,787	0	68.00
69.00	06900	ELECTROCARDIOLOGY	193,521	943,554	182,113	62,880	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,647,145	510,918	23,066	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,783,276	344,185	111,581	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	183,009	822,683	158,784	0	9,920	88.00
90.00	09000	CLINIC	519,029	1,855,998	358,221	230,932	0	90.00
90.01	09001	WOUND CLINC	81,963	332,751	64,223	13,800	0	90.01
91.00	09100	EMERGENCY	564,637	2,881,248	556,101	278,003	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	458,612	1,995,110	385,070	76,255	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	230,409	1,216,698	234,831	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,227,624	61,087,031	9,437,774	2,645,471	9,920	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,737,057	13,035,027	2,515,824	419,907	117,886	192.00
192.01	19201	PRIVATE DUTY	0	0	0	0	0	192.01
194.00	07950	COMMUNITY RELATIONS	46,013	518,593	100,092	5,649	0	194.00
194.01	07951	COMMUNITY BENEFITS	122,229	623,725	120,383	41,779	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	3,476	13,070	2,523	0	0	194.02
194.03	07953	EMS	4,854	61,345	11,840	0	0	194.03
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,141,253	75,338,791	12,188,436	3,112,806	127,806	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/26/2016 11:49 am

		Cost Center Description	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.02	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	807,180					7.02
8.00	00800	LAUNDRY & LINEN SERVICE	12,430	352,980				8.00
9.00	00900	HOUSEKEEPING	13,315	15,417	1,537,798			9.00
10.00	01000	DIETARY	5,998	409	11,266	323,705		10.00
11.00	01100	CAFETERIA	31,665	2,158	59,474	0	1,702,684	11.00
13.00	01300	NURSING ADMINISTRATION	2,814	0	5,286	0	66,759	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,820	0	0	0	14.00
15.00	01500	PHARMACY	3,781	0	7,102	0	48,645	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,571	0	31,125	0	121,150	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	84,709	86,662	159,104	304,709	274,120	30.00
31.00	03100	INTENSIVE CARE UNIT	8,224	4,505	15,447	18,996	47,302	31.00
43.00	04300	NURSERY	4,192	17,686	7,873	0	60,756	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,525	37,583	40,429	0	171,198	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,435	1,666	13,965	0	11,489	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	91,861	40,684	172,537	0	162,895	54.00
60.00	06000	LABORATORY	22,912	0	43,034	0	194,589	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	18,793	7,511	35,297	0	59,543	65.00
66.00	06600	PHYSICAL THERAPY	22,305	31,379	41,894	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,939	0	11,155	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,225	0	6,057	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,845	735	24,126	0	58,771	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,712	0	8,850	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	22,793	18,675	42,811	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	17,105	0	32,127	0	0	88.00
90.00	09000	CLINIC	47,174	30,502	88,603	0	0	90.00
90.01	09001	WOUND CLINC	2,819	0	5,295	0	0	90.01
91.00	09100	EMERGENCY	56,789	45,730	106,663	0	207,637	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	15,577	0	29,257	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	557,508	347,122	998,777	323,705	1,484,854	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	239,984	5,858	520,824	0	161,131	192.00
192.01	19201	PRIVATE DUTY	0	0	0	0	0	192.01
194.00	07950	COMMUNITY RELATIONS	1,154	0	2,168	0	15,821	194.00
194.01	07951	COMMUNITY BENEFITS	8,534	0	16,029	0	38,913	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	1,965	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)	807,180	352,980	1,537,798	323,705	1,702,684	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/26/2016 11:49 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
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	1,261,229					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,948				14.00
15.00	01500	PHARMACY	55,361	1	3,865,700			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2	0	1,985,964		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	311,965	104	0	1,158,284	6,701,253	30.00
31.00	03100	INTENSIVE CARE UNIT	53,833	9	0	0	843,852	31.00
43.00	04300	NURSERY	69,144	0	0	0	1,103,988	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,145	0	114,890	3,160,607	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,075	89	0	0	304,676	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	185,331	378	0	483,009	12,017,885	54.00
60.00	06000	LABORATORY	221,454	1,342	0	0	5,068,463	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	67,764	96	0	0	1,229,348	65.00
66.00	06600	PHYSICAL THERAPY	0	19	0	0	1,990,950	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18	0	0	642,285	67.00
68.00	06800	SPEECH PATHOLOGY	0	1	0	0	336,991	68.00
69.00	06900	ELECTROCARDIOLOGY	44,761	37	0	21,102	1,350,924	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,194,691	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,323,321	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,865,700	0	3,865,700	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	9	0	0	1,040,628	88.00
90.00	09000	CLINIC	0	212	0	79,720	2,691,362	90.00
90.01	09001	WOUND CLINC	0	163	0	0	419,051	90.01
91.00	09100	EMERGENCY	236,304	115	0	79,720	4,448,310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	32	0	0	2,501,301	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	14	0	0	1,451,543	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,258,992	5,786	3,865,700	1,936,725	56,687,129	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	156	0	49,239	17,065,836	192.00
192.01	19201	PRIVATE DUTY	0	0	0	0	0	192.01
194.00	07950	COMMUNITY RELATIONS	0	0	0	0	643,477	194.00
194.01	07951	COMMUNITY BENEFITS	0	6	0	0	849,369	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	15,593	194.02
194.03	07953	EMS	2,237	0	0	0	77,387	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,261,229	5,948	3,865,700	1,985,964	75,338,791	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/26/2016 11:49 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT -OFFSITE				7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS				7.02
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	6,701,253		30.00
31.00	03100	INTENSIVE CARE UNIT	0	843,852		31.00
43.00	04300	NURSERY	0	1,103,988		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,160,607		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	304,676		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,017,885		54.00
60.00	06000	LABORATORY	0	5,068,463		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	1,229,348		65.00
66.00	06600	PHYSICAL THERAPY	0	1,990,950		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	642,285		67.00
68.00	06800	SPEECH PATHOLOGY	0	336,991		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,350,924		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,194,691		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,323,321		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,865,700		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,040,628		88.00
90.00	09000	CLINIC	0	2,691,362		90.00
90.01	09001	WOUND CLINC	0	419,051		90.01
91.00	09100	EMERGENCY	0	4,448,310		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	2,501,301		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	1,451,543		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	56,687,129		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	17,065,836		192.00
192.01	19201	PRIVATE DUTY	0	0		192.01
194.00	07950	COMMUNITY RELATIONS	0	643,477		194.00
194.01	07951	COMMUNITY BENEFITS	0	849,369		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	15,593		194.02
194.03	07953	EMS	0	77,387		194.03
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	75,338,791		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/26/2016 11:49 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,940	0	18,593	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	260,018	0	441,928	0	5.00
7.00	00700	OPERATION OF PLANT	0	486,824	0	827,408	0	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,784	0	45,523	0	8.00
9.00	00900	HOUSEKEEPING	0	28,691	0	48,763	0	9.00
10.00	01000	DIETARY	0	12,925	0	21,968	0	10.00
11.00	01100	CAFETERIA	0	68,233	0	115,970	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,065	0	10,307	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	8,148	0	13,849	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,709	0	60,691	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	182,535	0	310,238	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	17,722	0	30,120	0	31.00
43.00	04300	NURSERY	0	9,033	0	15,352	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	46,383	0	78,833	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	16,021	0	27,230	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	197,947	0	336,433	0	54.00
60.00	06000	LABORATORY	0	49,371	0	83,912	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	40,496	0	68,827	0	65.00
66.00	06600	PHYSICAL THERAPY	0	48,064	0	81,690	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,797	0	21,751	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,949	0	11,811	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	27,679	0	47,043	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,153	0	17,257	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	49,116	0	83,478	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	47,410	0	12,308	88.00
90.00	09000	CLINIC	0	101,652	0	172,769	0	90.00
90.01	09001	WOUND CLINC	0	6,074	0	10,324	0	90.01
91.00	09100	EMERGENCY	0	122,372	0	207,984	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	33,566	0	57,049	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,922,267	47,410	3,267,101	12,308	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	184,835	563,417	314,148	146,265	192.00
192.01	19201	PRIVATE DUTY	0	0	0	0	0	192.01
194.00	07950	COMMUNITY RELATIONS	0	2,487	0	4,226	0	194.00
194.01	07951	COMMUNITY BENEFITS	0	18,390	0	31,256	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	2,127,979	610,827	3,616,731	158,573	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/26/2016 11:49 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
			2A	4.00	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	29,533	29,533				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	701,946	4,377	706,323			5.00
7.00	00700	OPERATION OF PLANT	1,314,232	0	29,184	1,343,416		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	1,198	0	1,198	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	433	7,568	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	72,307	73	2,622	26,261	0	8.00
9.00	00900	HOUSEKEEPING	77,454	566	13,537	28,130	0	9.00
10.00	01000	DIETARY	34,893	111	2,594	12,673	0	10.00
11.00	01100	CAFETERIA	184,203	583	13,635	66,900	0	11.00
13.00	01300	NURSING ADMINISTRATION	16,372	617	10,994	5,946	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1	0	0	14.00
15.00	01500	PHARMACY	21,997	501	34,992	7,989	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	96,400	786	16,276	35,011	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	492,773	1,827	36,629	178,967	0	30.00
31.00	03100	INTENSIVE CARE UNIT	47,842	320	6,144	17,375	0	31.00
43.00	04300	NURSERY	24,385	445	8,661	8,856	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	125,216	1,175	24,999	45,477	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	43,251	84	2,068	15,708	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	534,380	2,343	97,800	194,077	0	54.00
60.00	06000	LABORATORY	133,283	1,087	41,936	48,406	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	109,323	389	8,891	39,704	0	65.00
66.00	06600	PHYSICAL THERAPY	129,754	855	16,746	47,125	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	34,548	295	5,589	12,547	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,760	157	2,924	6,813	0	68.00
69.00	06900	ELECTROCARDIOLOGY	74,722	471	10,554	27,138	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,410	0	29,608	9,955	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	132,594	0	19,946	48,156	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	59,718	445	9,202	0	93	88.00
90.00	09000	CLINIC	274,421	1,263	20,759	99,665	0	90.00
90.01	09001	WOUND CLINC	16,398	199	3,722	5,956	0	90.01
91.00	09100	EMERGENCY	330,356	1,374	32,227	119,980	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	90,615	1,116	22,315	32,910	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	561	13,609	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,249,086	22,453	546,930	1,141,725	93	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,208,665	6,651	145,785	181,222	1,105	192.00
192.01	19201	PRIVATE DUTY	0	0	0	0	0	192.01
194.00	07950	COMMUNITY RELATIONS	6,713	112	5,800	2,438	0	194.00
194.01	07951	COMMUNITY BENEFITS	49,646	297	6,976	18,031	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	8	146	0	0	194.02
194.03	07953	EMS	0	12	686	0	0	194.03
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,514,110	29,533	706,323	1,343,416	1,198	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/26/2016 11:49 am

		Cost Center Description	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.02	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	8,001					7.02
8.00	00800	LAUNDRY & LINEN SERVICE	123	101,386				8.00
9.00	00900	HOUSEKEEPING	132	4,428	124,247			9.00
10.00	01000	DIETARY	59	117	910	51,357		10.00
11.00	01100	CAFETERIA	314	620	4,805	0	271,060	11.00
13.00	01300	NURSING ADMINISTRATION	28	0	427	0	10,628	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,672	0	0	0	14.00
15.00	01500	PHARMACY	37	0	574	0	7,744	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	164	0	2,515	0	19,287	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	840	24,891	12,855	48,343	43,638	30.00
31.00	03100	INTENSIVE CARE UNIT	82	1,294	1,248	3,014	7,530	31.00
43.00	04300	NURSERY	42	5,080	636	0	9,672	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	213	10,795	3,266	0	27,254	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	74	479	1,128	0	1,829	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	911	11,686	13,940	0	25,932	54.00
60.00	06000	LABORATORY	227	0	3,477	0	30,978	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	186	2,157	2,852	0	9,479	65.00
66.00	06600	PHYSICAL THERAPY	221	9,013	3,385	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	59	0	901	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	32	0	489	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	127	211	1,949	0	9,356	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	47	0	715	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	226	5,364	3,459	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	170	0	2,596	0	0	88.00
90.00	09000	CLINIC	468	8,761	7,159	0	0	90.00
90.01	09001	WOUND CLINC	28	0	428	0	0	90.01
91.00	09100	EMERGENCY	563	13,135	8,618	0	33,055	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	154	0	2,364	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,527	99,703	80,696	51,357	236,382	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,378	1,683	42,081	0	25,651	192.00
192.01	19201	PRIVATE DUTY	0	0	0	0	0	192.01
194.00	07950	COMMUNITY RELATIONS	11	0	175	0	2,519	194.00
194.01	07951	COMMUNITY BENEFITS	85	0	1,295	0	6,195	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	313	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)	8,001	101,386	124,247	51,357	271,060	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/26/2016 11:49 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
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	45,012					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,673				14.00
15.00	01500	PHARMACY	1,976	0	75,810			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1	0	170,440		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,135	29	0	99,406	951,333	30.00
31.00	03100	INTENSIVE CARE UNIT	1,921	3	0	0	86,773	31.00
43.00	04300	NURSERY	2,468	0	0	0	60,245	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	884	0	9,860	249,139	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	467	25	0	0	65,113	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,614	106	0	41,453	929,242	54.00
60.00	06000	LABORATORY	7,903	378	0	0	267,675	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,418	27	0	0	175,426	65.00
66.00	06600	PHYSICAL THERAPY	0	5	0	0	207,104	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5	0	0	53,944	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	29,175	68.00
69.00	06900	ELECTROCARDIOLOGY	1,597	10	0	1,811	127,946	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	67,735	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	209,745	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	75,810	0	75,810	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3	0	0	72,227	88.00
90.00	09000	CLINIC	0	60	0	6,842	419,398	90.00
90.01	09001	WOUND CLINC	0	46	0	0	26,777	90.01
91.00	09100	EMERGENCY	8,433	32	0	6,842	554,615	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	9	0	0	149,483	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	4	0	0	14,174	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	44,932	1,627	75,810	166,214	4,793,079	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	44	0	4,226	1,619,491	192.00
192.01	19201	PRIVATE DUTY	0	0	0	0	0	192.01
194.00	07950	COMMUNITY RELATIONS	0	0	0	0	17,768	194.00
194.01	07951	COMMUNITY BENEFITS	0	2	0	0	82,527	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	154	194.02
194.03	07953	EMS	80	0	0	0	1,091	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	45,012	1,673	75,810	170,440	6,514,110	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/26/2016 11:49 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT -OFFSITE				7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS				7.02
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	951,333		30.00
31.00	03100	INTENSIVE CARE UNIT	0	86,773		31.00
43.00	04300	NURSERY	0	60,245		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	249,139		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	65,113		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	929,242		54.00
60.00	06000	LABORATORY	0	267,675		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	175,426		65.00
66.00	06600	PHYSICAL THERAPY	0	207,104		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	53,944		67.00
68.00	06800	SPEECH PATHOLOGY	0	29,175		68.00
69.00	06900	ELECTROCARDIOLOGY	0	127,946		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	67,735		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	209,745		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	75,810		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	72,227		88.00
90.00	09000	CLINIC	0	419,398		90.00
90.01	09001	WOUND CLINC	0	26,777		90.01
91.00	09100	EMERGENCY	0	554,615		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	149,483		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	14,174		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,793,079		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,619,491		192.00
192.01	19201	PRIVATE DUTY	0	0		192.01
194.00	07950	COMMUNITY RELATIONS	0	17,768		194.00
194.01	07951	COMMUNITY BENEFITS	0	82,527		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	154		194.02
194.03	07953	EMS	0	1,091		194.03
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	6,514,110		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 11:49 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	216,499					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	0	48,315				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			216,499			2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT			0	48,315		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,113	0	1,113	0	33,417,670	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,454	0	26,454	0	4,951,380	5.00
7.00	00700	OPERATION OF PLANT	49,529	0	49,529	0	0	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	489,625	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,725	0	2,725	0	82,256	8.00
9.00	00900	HOUSEKEEPING	2,919	0	2,919	0	640,496	9.00
10.00	01000	DIETARY	1,315	0	1,315	0	125,005	10.00
11.00	01100	CAFETERIA	6,942	0	6,942	0	660,018	11.00
13.00	01300	NURSING ADMINISTRATION	617	0	617	0	698,209	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	829	0	829	0	566,420	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,633	0	3,633	0	888,657	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,571	0	18,571	0	2,066,859	30.00
31.00	03100	INTENSIVE CARE UNIT	1,803	0	1,803	0	362,382	31.00
43.00	04300	NURSERY	919	0	919	0	503,351	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,719	0	4,719	0	1,329,180	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,630	0	1,630	0	95,169	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,139	0	20,139	0	2,650,194	54.00
60.00	06000	LABORATORY	5,023	0	5,023	0	1,229,700	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	4,120	0	4,120	0	439,596	65.00
66.00	06600	PHYSICAL THERAPY	4,890	0	4,890	0	967,266	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,302	0	1,302	0	333,664	67.00
68.00	06800	SPEECH PATHOLOGY	707	0	707	0	177,653	68.00
69.00	06900	ELECTROCARDIOLOGY	2,816	0	2,816	0	532,650	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,033	0	1,033	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,997	0	4,997	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,750	0	3,750	503,716	88.00
90.00	09000	CLINIC	10,342	0	10,342	0	1,428,581	90.00
90.01	09001	WOUND CLINC	618	0	618	0	225,595	90.01
91.00	09100	EMERGENCY	12,450	0	12,450	0	1,554,112	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,415	0	3,415	0	1,262,287	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	634,181	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	195,570	3,750	195,570	3,750	25,398,202	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,805	44,565	18,805	44,565	7,533,468	192.00
192.01	19201	PRIVATE DUTY	0	0	0	0	0	192.01
194.00	07950	COMMUNITY RELATIONS	253	0	253	0	126,648	194.00
194.01	07951	COMMUNITY BENEFITS	1,871	0	1,871	0	336,424	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	9,567	194.02
194.03	07953	EMS	0	0	0	0	13,361	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)	2,127,979	610,827	3,616,731	158,573	12,141,253	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.829048	12.642595	16.705532	3.282066	0.363318	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					29,533	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000884	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 11:49 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	
			5A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-12,188,436	63,150,355				5.00
7.00	00700	OPERATION OF PLANT	0	2,609,210	139,403			7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	107,129	0	48,315		7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	676,593	0	0	176,960	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	234,451	2,725	0	2,725	8.00
9.00	00900	HOUSEKEEPING	0	1,210,291	2,919	0	2,919	9.00
10.00	01000	DIETARY	0	231,909	1,315	0	1,315	10.00
11.00	01100	CAFETERIA	0	1,219,083	6,942	0	6,942	11.00
13.00	01300	NURSING ADMINISTRATION	0	982,889	617	0	617	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	107	0	0	0	14.00
15.00	01500	PHARMACY	0	3,128,480	829	0	829	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,455,141	3,633	0	3,633	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,274,846	18,571	0	18,571	30.00
31.00	03100	INTENSIVE CARE UNIT	0	549,264	1,803	0	1,803	31.00
43.00	04300	NURSERY	0	774,359	919	0	919	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,235,078	4,719	0	4,719	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	184,877	1,630	0	1,630	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,743,866	20,139	0	20,139	54.00
60.00	06000	LABORATORY	0	3,749,325	5,023	0	5,023	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	794,921	4,120	0	4,120	65.00
66.00	06600	PHYSICAL THERAPY	0	1,497,193	4,890	0	4,890	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	499,662	1,302	0	1,302	67.00
68.00	06800	SPEECH PATHOLOGY	0	261,458	707	0	707	68.00
69.00	06900	ELECTROCARDIOLOGY	0	943,554	2,816	0	2,816	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,647,145	1,033	0	1,033	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,783,276	4,997	0	4,997	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	822,683	0	3,750	3,750	88.00
90.00	09000	CLINIC	0	1,855,998	10,342	0	10,342	90.00
90.01	09001	WOUND CLINC	0	332,751	618	0	618	90.01
91.00	09100	EMERGENCY	0	2,881,248	12,450	0	12,450	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,995,110	3,415	0	3,415	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,216,698	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-12,188,436	48,898,595	118,474	3,750	122,224	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	13,035,027	18,805	44,565	52,612	192.00
192.01	19201	PRIVATE DUTY	0	0	0	0	0	192.01
194.00	07950	COMMUNITY RELATIONS	0	518,593	253	0	253	194.00
194.01	07951	COMMUNITY BENEFITS	0	623,725	1,871	0	1,871	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	13,070	0	0	0	194.02
194.03	07953	EMS	0	61,345	0	0	0	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)		12,188,436	3,112,806	127,806	807,180	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.193007	22.329548	2.645265	4.561370	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		706,323	1,343,416	1,198	8,001	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.011185	9.636923	0.024796	0.045214	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 11:49 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	276,276					8.00
9.00	00900	HOUSEKEEPING	12,067	179,496				9.00
10.00	01000	DIETARY	320	1,315	17,654			10.00
11.00	01100	CAFETERIA	1,689	6,942	0	432,311		11.00
13.00	01300	NURSING ADMINISTRATION	0	617	0	16,950	281,378	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,555	0	0	0	0	14.00
15.00	01500	PHARMACY	0	829	0	12,351	12,351	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,633	0	30,760	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67,830	18,571	16,618	69,599	69,599	30.00
31.00	03100	INTENSIVE CARE UNIT	3,526	1,803	1,036	12,010	12,010	31.00
43.00	04300	NURSERY	13,843	919	0	15,426	15,426	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,416	4,719	0	43,467	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,304	1,630	0	2,917	2,917	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,843	20,139	0	41,359	41,347	54.00
60.00	06000	LABORATORY	0	5,023	0	49,406	49,406	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	5,879	4,120	0	15,118	15,118	65.00
66.00	06600	PHYSICAL THERAPY	24,560	4,890	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,302	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	707	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	575	2,816	0	14,922	9,986	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,033	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,617	4,997	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,750	0	0	0	88.00
90.00	09000	CLINIC	23,874	10,342	0	0	0	90.00
90.01	09001	WOUND CLINC	0	618	0	0	0	90.01
91.00	09100	EMERGENCY	35,793	12,450	0	52,719	52,719	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	3,415	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	271,691	116,580	17,654	377,004	280,879	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,585	60,792	0	40,911	0	192.00
192.01	19201	PRIVATE DUTY	0	0	0	0	0	192.01
194.00	07950	COMMUNITY RELATIONS	0	253	0	4,017	0	194.00
194.01	07951	COMMUNITY BENEFITS	0	1,871	0	9,880	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	499	499	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)	352,980	1,537,798	323,705	1,702,684	1,261,229	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.277635	8.567311	18.336071	3.938563	4.482330	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	101,386	124,247	51,357	271,060	45,012	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.366974	0.692199	2.909086	0.627002	0.159970	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 11:49 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (100% PHARMACY)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT -OFFSITE					7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS					7.02
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,545,548				14.00
15.00	01500	PHARMACY	1,227	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,709	0	847		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	97,185	0	494		30.00
31.00	03100	INTENSIVE CARE UNIT	8,660	0	0		31.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,932,724	0	49		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	82,694	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	352,226	0	206		54.00
60.00	06000	LABORATORY	1,250,331	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	89,267	0	0		65.00
66.00	06600	PHYSICAL THERAPY	17,904	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	16,537	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	958	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	34,486	0	9		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	8,819	0	0		88.00
90.00	09000	CLINIC	197,951	0	34		90.00
90.01	09001	WOUND CLINC	151,561	0	0		90.01
91.00	09100	EMERGENCY	106,927	0	34		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	30,252	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	13,256	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,394,674	100	826		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	145,049	0	21		192.00
192.01	19201	PRIVATE DUTY	0	0	0		192.01
194.00	07950	COMMUNITY RELATIONS	0	0	0		194.00
194.01	07951	COMMUNITY BENEFITS	5,825	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.02
194.03	07953	EMS	0	0	0		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)	5,948	3,865,700	1,985,964		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001073	38,657.000000	2,344.703660		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,673	75,810	170,440		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000302	758.100000	201.227863		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 11:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,701,253		6,701,253	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	843,852		843,852	0	0	31.00
43.00	04300	NURSERY	1,103,988		1,103,988	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,160,607		3,160,607	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	304,676		304,676	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,017,885		12,017,885	0	0	54.00
60.00	06000	LABORATORY	5,068,463		5,068,463	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,229,348	0	1,229,348	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,990,950	0	1,990,950	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	642,285	0	642,285	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	336,991	0	336,991	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,350,924		1,350,924	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,194,691		3,194,691	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,323,321		2,323,321	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,865,700		3,865,700	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,040,628		1,040,628	0	0	88.00
90.00	09000	CLINIC	2,691,362		2,691,362	0	0	90.00
90.01	09001	WOUND CLINC	419,051		419,051	0	0	90.01
91.00	09100	EMERGENCY	4,448,310		4,448,310	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,189,030		1,189,030		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,501,301		2,501,301		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,451,543		1,451,543		0	116.00
200.00		Subtotal (see instructions)	57,876,159	0	57,876,159	0	0	200.00
201.00		Less Observation Beds	1,189,030		1,189,030		0	201.00
202.00		Total (see instructions)	56,687,129	0	56,687,129	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 11:49 am

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	4,732,165		4,732,165			30.00
31.00	03100	INTENSIVE CARE UNIT	495,255		495,255			31.00
43.00	04300	NURSERY	2,227,221		2,227,221			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,670,928	12,369,321	16,040,249	0.197042	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	188,075	31,726	219,801	1.386145	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,358,258	50,277,154	51,635,412	0.232745	0.000000	54.00
60.00	06000	LABORATORY	3,024,801	20,719,397	23,744,198	0.213461	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	2,086,601	687,315	2,773,916	0.443181	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	247,543	3,163,128	3,410,671	0.583741	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	103,853	979,387	1,083,240	0.592930	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	68,748	305,510	374,258	0.900424	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	457,930	3,724,398	4,182,328	0.323008	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,241,096	4,229,055	7,470,151	0.427661	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,223,434	1,124,307	2,347,741	0.989599	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,439,886	8,360,662	11,800,548	0.327586	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	637,463	637,463			88.00
90.00	09000	CLINIC	166,685	5,577,799	5,744,484	0.468512	0.000000	90.00
90.01	09001	WOUND CLINC	5,045	1,430,288	1,435,333	0.291954	0.000000	90.01
91.00	09100	EMERGENCY	251,513	6,682,000	6,933,513	0.641567	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	13,985	929,160	943,145	1.260708	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	25	1,871,486	1,871,511			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,782,338	1,782,338			116.00
200.00		Subtotal (see instructions)	27,003,047	124,881,894	151,884,941			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	27,003,047	124,881,894	151,884,941			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 11:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CLINC	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 11:49 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,701,253		6,701,253	0	6,701,253	30.00
31.00	03100	INTENSIVE CARE UNIT	843,852		843,852	0	843,852	31.00
43.00	04300	NURSERY	1,103,988		1,103,988	0	1,103,988	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,160,607		3,160,607	0	3,160,607	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	304,676		304,676	0	304,676	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,017,885		12,017,885	0	12,017,885	54.00
60.00	06000	LABORATORY	5,068,463		5,068,463	0	5,068,463	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,229,348	0	1,229,348	0	1,229,348	65.00
66.00	06600	PHYSICAL THERAPY	1,990,950	0	1,990,950	0	1,990,950	66.00
67.00	06700	OCCUPATIONAL THERAPY	642,285	0	642,285	0	642,285	67.00
68.00	06800	SPEECH PATHOLOGY	336,991	0	336,991	0	336,991	68.00
69.00	06900	ELECTROCARDIOLOGY	1,350,924		1,350,924	0	1,350,924	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,194,691		3,194,691	0	3,194,691	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,323,321		2,323,321	0	2,323,321	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,865,700		3,865,700	0	3,865,700	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,040,628		1,040,628	0	1,040,628	88.00
90.00	09000	CLINIC	2,691,362		2,691,362	0	2,691,362	90.00
90.01	09001	WOUND CLINC	419,051		419,051	0	419,051	90.01
91.00	09100	EMERGENCY	4,448,310		4,448,310	0	4,448,310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,189,030		1,189,030		1,189,030	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,501,301		2,501,301		2,501,301	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,451,543		1,451,543		1,451,543	116.00
200.00		Subtotal (see instructions)	57,876,159	0	57,876,159	0	57,876,159	200.00
201.00		Less Observation Beds	1,189,030		1,189,030		1,189,030	201.00
202.00		Total (see instructions)	56,687,129	0	56,687,129	0	56,687,129	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 11:49 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,732,165		4,732,165			30.00
31.00	03100	INTENSIVE CARE UNIT	495,255		495,255			31.00
43.00	04300	NURSERY	2,227,221		2,227,221			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,670,928	12,369,321	16,040,249	0.197042	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	188,075	31,726	219,801	1.386145	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,358,258	50,277,154	51,635,412	0.232745	0.000000	54.00
60.00	06000	LABORATORY	3,024,801	20,719,397	23,744,198	0.213461	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	2,086,601	687,315	2,773,916	0.443181	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	247,543	3,163,128	3,410,671	0.583741	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	103,853	979,387	1,083,240	0.592930	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	68,748	305,510	374,258	0.900424	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	457,930	3,724,398	4,182,328	0.323008	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,241,096	4,229,055	7,470,151	0.427661	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,223,434	1,124,307	2,347,741	0.989599	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,439,886	8,360,662	11,800,548	0.327586	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	637,463	637,463	1.632452	0.000000	88.00
90.00	09000	CLINIC	166,685	5,577,799	5,744,484	0.468512	0.000000	90.00
90.01	09001	WOUND CLINC	5,045	1,430,288	1,435,333	0.291954	0.000000	90.01
91.00	09100	EMERGENCY	251,513	6,682,000	6,933,513	0.641567	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	13,985	929,160	943,145	1.260708	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	25	1,871,486	1,871,511			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,782,338	1,782,338			116.00
200.00		Subtotal (see instructions)	27,003,047	124,881,894	151,884,941			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	27,003,047	124,881,894	151,884,941			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 11:49 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CLINC	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/26/2016 11:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	249,139	16,040,249	0.015532	1,202,212	18,673	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	65,113	219,801	0.296236	2,587	766	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	929,242	51,635,412	0.017996	707,193	12,727	54.00
60.00	06000	LABORATORY	267,675	23,744,198	0.011273	1,556,287	17,544	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	175,426	2,773,916	0.063241	1,394,538	88,192	65.00
66.00	06600	PHYSICAL THERAPY	207,104	3,410,671	0.060722	159,562	9,689	66.00
67.00	06700	OCCUPATIONAL THERAPY	53,944	1,083,240	0.049799	66,883	3,331	67.00
68.00	06800	SPEECH PATHOLOGY	29,175	374,258	0.077954	54,182	4,224	68.00
69.00	06900	ELECTROCARDIOLOGY	127,946	4,182,328	0.030592	289,739	8,864	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	67,735	7,470,151	0.009067	1,261,073	11,434	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	209,745	2,347,741	0.089339	688,088	61,473	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,810	11,800,548	0.006424	1,711,989	10,998	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	72,227	637,463	0.113304	0	0	88.00
90.00	09000	CLINIC	419,398	5,744,484	0.073009	94,615	6,908	90.00
90.01	09001	WOUND CLINC	26,777	1,435,333	0.018656	3,428	64	90.01
91.00	09100	EMERGENCY	554,615	6,933,513	0.079990	33,134	2,650	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	168,798	943,145	0.178974	0	0	92.00
200.00		Total (lines 50-199)	3,699,869	140,776,451		9,225,510	257,537	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 11:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 11:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	16,040,249	0.000000	0.000000	1,202,212	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	219,801	0.000000	0.000000	2,587	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	51,635,412	0.000000	0.000000	707,193	54.00
60.00	06000	LABORATORY	0	23,744,198	0.000000	0.000000	1,556,287	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	2,773,916	0.000000	0.000000	1,394,538	65.00
66.00	06600	PHYSICAL THERAPY	0	3,410,671	0.000000	0.000000	159,562	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,083,240	0.000000	0.000000	66,883	67.00
68.00	06800	SPEECH PATHOLOGY	0	374,258	0.000000	0.000000	54,182	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,182,328	0.000000	0.000000	289,739	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,470,151	0.000000	0.000000	1,261,073	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,347,741	0.000000	0.000000	688,088	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,800,548	0.000000	0.000000	1,711,989	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	637,463	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	5,744,484	0.000000	0.000000	94,615	90.00
90.01	09001	WOUND CLINC	0	1,435,333	0.000000	0.000000	3,428	90.01
91.00	09100	EMERGENCY	0	6,933,513	0.000000	0.000000	33,134	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	943,145	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	140,776,451			9,225,510	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 11:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CLINC	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/26/2016 11:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.197042	0	2,989,945	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.386145	0	406	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232745	0	17,872,626	3,342	0	54.00
60.00	06000	LABORATORY	0.213461	0	5,432,416	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.443181	0	247,055	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.583741	0	836,163	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.592930	0	241,055	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.900424	0	34,557	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.323008	0	1,430,869	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.427661	0	1,238,759	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.989599	0	385,421	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.327586	0	3,047,139	825	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.468512	0	1,755,603	0	0	90.00
90.01	09001	WOUND CLINC	0.291954	0	586,723	53	0	90.01
91.00	09100	EMERGENCY	0.641567	0	1,785,906	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.260708	0	409,443	527	0	92.00
200.00		Subtotal (see instructions)		0	38,294,086	4,747	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	38,294,086	4,747	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/26/2016 11:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	589,145	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	563	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,159,764	778		54.00
60.00	06000	LABORATORY	1,159,609	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	109,490	0		65.00
66.00	06600	PHYSICAL THERAPY	488,103	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	142,929	0		67.00
68.00	06800	SPEECH PATHOLOGY	31,116	0		68.00
69.00	06900	ELECTROCARDIOLOGY	462,182	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	529,769	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	381,412	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	998,200	270		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	822,521	0		90.00
90.01	09001	WOUND CLINC	171,296	15		90.01
91.00	09100	EMERGENCY	1,145,778	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	516,188	664		92.00
200.00		Subtotal (see instructions)	11,708,065	1,727		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	11,708,065	1,727		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 11:49 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,309	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,309	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,367	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,914	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,701,253	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,701,253	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,701,253	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)	1,262.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,415,927	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,415,927	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 11:49 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	843,852	360	2,344.03	205	480,526	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)	3,478,137	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,374,590	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	942	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,262.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,189,030	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 11:49 am

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	951,333	6,701,253	0.141963	1,189,030	168,798	90.00
91.00	Nursing School cost	0	6,701,253	0.000000	1,189,030	0	91.00
92.00	Allied health cost	0	6,701,253	0.000000	1,189,030	0	92.00
93.00	All other Medical Education	0	6,701,253	0.000000	1,189,030	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 11:49 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,309	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,309	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,367	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	139	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	928	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,701,253	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,701,253	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,701,253	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)	1,262.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	175,451	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)	175,451	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 11:49 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,103,988	928	1,189.64	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	843,852	360	2,344.03	3	7,032	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)	216,464	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	398,947	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	942	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,262.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,189,030	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 11:49 am

Title XIX | 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	951,333	6,701,253	0.141963	1,189,030	168,798	90.00
91.00	Nursing School cost	0	6,701,253	0.000000	1,189,030	0	91.00
92.00	Allied health cost	0	6,701,253	0.000000	1,189,030	0	92.00
93.00	All other Medical Education	0	6,701,253	0.000000	1,189,030	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/26/2016 11:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,827,785		30.00
31.00	03100	INTENSIVE CARE UNIT		351,162		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.197042	1,202,212	236,886	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.386145	2,587	3,586	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232745	707,193	164,596	54.00
60.00	06000	LABORATORY	0.213461	1,556,287	332,207	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.443181	1,394,538	618,033	65.00
66.00	06600	PHYSICAL THERAPY	0.583741	159,562	93,143	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.592930	66,883	39,657	67.00
68.00	06800	SPEECH PATHOLOGY	0.900424	54,182	48,787	68.00
69.00	06900	ELECTROCARDIOLOGY	0.323008	289,739	93,588	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.427661	1,261,073	539,312	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.989599	688,088	680,931	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.327586	1,711,989	560,824	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.468512	94,615	44,328	90.00
90.01	09001	WOUND CLINC	0.291954	3,428	1,001	90.01
91.00	09100	EMERGENCY	0.641567	33,134	21,258	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.260708	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		9,225,510	3,478,137	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)		9,225,510		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/26/2016 11:49 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		154,101		30.00
31.00	03100	INTENSIVE CARE UNIT		8,121		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.197042	21,630	4,262	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.386145	48,165	66,764	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232745	13,944	3,245	54.00
60.00	06000	LABORATORY	0.213461	80,871	17,263	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.443181	26,039	11,540	65.00
66.00	06600	PHYSICAL THERAPY	0.583741	608	355	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.592930	261	155	67.00
68.00	06800	SPEECH PATHOLOGY	0.900424	5,092	4,585	68.00
69.00	06900	ELECTROCARDIOLOGY	0.323008	5,972	1,929	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.427661	171,976	73,547	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.989599	7,209	7,134	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.327586	78,007	25,554	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.632452	0	0	88.00
90.00	09000	CLINIC	0.468512	45	21	90.00
90.01	09001	WOUND CLINC	0.291954	0	0	90.01
91.00	09100	EMERGENCY	0.641567	172	110	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.260708	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		459,991	216,464	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)		459,991		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151329	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/26/2016 11:49 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	11,709,792	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)	11,709,792	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)	11,826,890	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)	99,464	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	6,583,333	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	5,144,093	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	5,144,093	30.00
31.00	Primary payer payments	3,800	31.00
32.00	Subtotal (line 30 minus line 31)	5,140,293	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	1,002,276	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	651,479	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	639,173	36.00
37.00	Subtotal (see instructions)	5,791,772	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)	5,791,772	40.00
40.01	Sequestration adjustment (see instructions)	115,835	40.01
41.00	Interim payments	6,271,256	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-595,319	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: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2016 11:49 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,950,977		6,271,256	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/16/2015	147,500		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)		147,500		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)		5,098,477		6,271,256	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		659,071		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		595,319	6.02
7.00	Total Medicare program liability (see instructions)		5,757,548		5,675,937	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: 151329	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/26/2016 11:49 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,661	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,119	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	378	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4,727	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	151,884,941	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	2,311,419	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	548,279	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	403,753	8.00
9.00	Sequestration adjustment amount (see instructions)	8,075	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	395,678	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)	395,678	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151329	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part V Date/Time Prepared: 5/26/2016 11:49 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	6,374,590	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)	6,374,590	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	6,438,336	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)	6,438,336	19.00
20.00	Deductibles (exclude professional component)	613,532	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	5,824,804	22.00
23.00	Coinsurance	315	23.00
24.00	Subtotal (line 22 minus line 23)	5,824,489	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	77,785	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	50,560	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	38,002	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,875,049	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)	5,875,049	30.00
30.01	Sequestration adjustment (see instructions)	117,501	30.01
31.00	Interim payments	5,098,477	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)	659,071	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: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-3 Part VII Date/Time Prepared: 5/26/2016 11:49 am

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	398,947		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)	398,947	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)	398,947	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	162,221		8.00
9.00	Ancillary service charges	459,991	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)	622,212	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	260,226	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)	622,212	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	223,265	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)	398,947	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)	398,947	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)	398,947	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)	398,947	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	398,947	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)	398,947	0	40.00
41.00	Interim payments	260,226	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	138,721	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: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/26/2016 11:49 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	6,114,396	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	11,840,873	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,868,830	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,700,167	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)	22,524,266	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,371,158	0	0	0	12.00
13.00	Land improvements	423,901	0	0	0	13.00
14.00	Accumulated depreciation	-376,753	0	0	0	14.00
15.00	Buildings	69,823,878	0	0	0	15.00
16.00	Accumulated depreciation	-36,623,022	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	6,341,285	0	0	0	19.00
20.00	Accumulated depreciation	-5,519,345	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	47,282,966	0	0	0	23.00
24.00	Accumulated depreciation	-29,463,969	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)	54,260,099	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	71,193,563	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	71,193,563	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	147,977,928	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,201,459	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,712,142	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,700,167	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,098,502	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,712,270	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	28,765,615	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	28,765,615	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	43,477,885	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	104,500,043				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)	104,500,043	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	147,977,928	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/26/2016 11:49 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		100,369,029		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,131,014				2.00
3.00	Total (sum of line 1 and line 2)		104,500,043		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)		104,500,043		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)		104,500,043		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: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2016 11:49 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,449,928		5,449,928	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,449,928		5,449,928	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	705,229		705,229	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)	705,229		705,229	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,155,157		6,155,157	17.00
18.00	Ancillary services	21,109,512	108,083,744	129,193,256	18.00
19.00	Outpatient services	561,221	20,394,326	20,955,547	19.00
20.00	RURAL HEALTH CLINIC	0	637,463	637,463	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,871,511	1,871,511	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,782,338	1,782,338	26.00
27.00	PHYSICIAN OFFICES	0	13,949,662	13,949,662	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	27,825,890	146,719,044	174,544,934	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		81,999,311		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		81,999,311		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-3 | Date/Time Prepared: 5/26/2016 11:49 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	174,544,934	1.00
2.00	Less contractual allowances and discounts on patients' accounts	87,358,773	2.00
3.00	Net patient revenues (line 1 minus line 2)	87,186,161	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	81,999,311	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,186,850	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	1,413	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	1,085,188	24.00
24.01	NONOPERATING GAIN	389,926	24.01
25.00	Total other income (sum of lines 6-24)	1,476,527	25.00
26.00	Total (line 5 plus line 25)	6,663,377	26.00
27.00	UNREALIZED LOSS ON DERIVATES	2,532,363	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2,532,363	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,131,014	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151329 | HHA CCN: 157143 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H | Date/Time Prepared: 5/26/2016 11:49 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	381,997	0	0	0	183,596	565,593	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	425,906	0	0	0	0	425,906	6.00
7.00	Physical Therapy	332,762	0	0	0	0	332,762	7.00
8.00	Occupational Therapy	68,143	0	0	0	0	68,143	8.00
9.00	Speech Pathology	1,339	0	0	0	0	1,339	9.00
10.00	Medical Social Services	14,182	0	0	0	0	14,182	10.00
11.00	Home Health Aide	37,958	0	0	0	0	37,958	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,262,287	0	0	0	183,596	1,445,883	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	565,593	0	565,593			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	425,906	0	425,906			6.00
7.00	Physical Therapy	0	332,762	0	332,762			7.00
8.00	Occupational Therapy	0	68,143	0	68,143			8.00
9.00	Speech Pathology	0	1,339	0	1,339			9.00
10.00	Medical Social Services	0	14,182	0	14,182			10.00
11.00	Home Health Aide	0	37,958	0	37,958			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	0	1,445,883	0	1,445,883			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: 151329 HHA CCN: 157143 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-1 Part I Date/Time Prepared: 5/26/2016 11:49 am

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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	565,593	0	0	0	0	565,593	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	425,906	0	0	0	0	425,906	6.00
7.00	Physical Therapy	332,762	0	0	0	0	332,762	7.00
8.00	Occupational Therapy	68,143	0	0	0	0	68,143	8.00
9.00	Speech Pathology	1,339	0	0	0	0	1,339	9.00
10.00	Medical Social Services	14,182	0	0	0	0	14,182	10.00
11.00	Home Health Aide	37,958	0	0	0	0	37,958	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,445,883	0	0	0	0	1,445,883	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	565,593		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	273,649	699,555	6.00
7.00	Physical Therapy	213,802	546,564	7.00
8.00	Occupational Therapy	43,782	111,925	8.00
9.00	Speech Pathology	860	2,199	9.00
10.00	Medical Social Services	9,112	23,294	10.00
11.00	Home Health Aide	24,388	62,346	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		1,445,883	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 151329 HHA CCN: 157143 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-1 Part II Date/Time Prepared: 5/26/2016 11:49 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-565,593	880,290	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	425,906	6.00
7.00	Physical Therapy	0	0	0	0	0	332,762	7.00
8.00	Occupational Therapy	0	0	0	0	0	68,143	8.00
9.00	Speech Pathology	0	0	0	0	0	1,339	9.00
10.00	Medical Social Services	0	0	0	0	0	14,182	10.00
11.00	Home Health Aide	0	0	0	0	0	37,958	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-565,593	880,290	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		565,593	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.642508	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part I
HHA CCN: 157143 | Date/Time Prepared: 5/26/2016 11:49 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	1.01	2.00	2.01	4.00	
1.00	Administrative and General	0	33,566	0	57,049	0	458,612	1.00
2.00	Skilled Nursing Care	699,555	0	0	0	0	0	2.00
3.00	Physical Therapy	546,564	0	0	0	0	0	3.00
4.00	Occupational Therapy	111,925	0	0	0	0	0	4.00
5.00	Speech Pathology	2,199	0	0	0	0	0	5.00
6.00	Medical Social Services	23,294	0	0	0	0	0	6.00
7.00	Home Health Aide	62,346	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)	1,445,883	33,566	0	57,049	0	458,612	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	
		4A	5.00	7.00	7.01	7.02	8.00	
1.00	Administrative and General	549,227	106,005	76,255	0	15,577	0	1.00
2.00	Skilled Nursing Care	699,555	135,019	0	0	0	0	2.00
3.00	Physical Therapy	546,564	105,491	0	0	0	0	3.00
4.00	Occupational Therapy	111,925	21,602	0	0	0	0	4.00
5.00	Speech Pathology	2,199	424	0	0	0	0	5.00
6.00	Medical Social Services	23,294	4,496	0	0	0	0	6.00
7.00	Home Health Aide	62,346	12,033	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)	1,995,110	385,070	76,255	0	15,577	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.000000						21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part I | Date/Time Prepared: 5/26/2016 11:49 am

HHA CCN: 157143 | Home Health Agency I | PPS

	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	29,257	0	0	0	32	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)	29,257	0	0	0	32	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY	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	776,353	0	776,353			1.00
2.00	Skilled Nursing Care	0	834,574	0	834,574	375,619	1,210,193	2.00
3.00	Physical Therapy	0	652,055	0	652,055	293,472	945,527	3.00
4.00	Occupational Therapy	0	133,527	0	133,527	60,097	193,624	4.00
5.00	Speech Pathology	0	2,623	0	2,623	1,181	3,804	5.00
6.00	Medical Social Services	0	27,790	0	27,790	12,508	40,298	6.00
7.00	Home Health Aide	0	74,379	0	74,379	33,476	107,855	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	2,501,301	0	2,501,301	776,353	2,501,301	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.					0.450073		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: 151329 HHA CCN: 157143 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part II Date/Time Prepared: 5/26/2016 11:49 am

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	Cost Center Description	CAPITAL RELATED COSTS						
		NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		1.00	1.01	2.00	2.01	4.00	5A	
1.00	Administrative and General	3,415	0	3,415	0	1,262,287	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)	3,415	0	3,415	0	1,262,287		20.00
21.00	Total cost to be allocated	33,566	0	57,049	0	458,612		21.00
22.00	Unit cost multiplier	9.828990	0.000000	16.705417	0.000000	0.363318		22.00

	Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5.00	7.00	7.01	7.02	8.00	9.00	
1.00	Administrative and General	549,227	3,415	0	3,415	0	3,415	1.00
2.00	Skilled Nursing Care	699,555	0	0	0	0	0	2.00
3.00	Physical Therapy	546,564	0	0	0	0	0	3.00
4.00	Occupational Therapy	111,925	0	0	0	0	0	4.00
5.00	Speech Pathology	2,199	0	0	0	0	0	5.00
6.00	Medical Social Services	23,294	0	0	0	0	0	6.00
7.00	Home Health Aide	62,346	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)	1,995,110	3,415	0	3,415	0	3,415	20.00
21.00	Total cost to be allocated	385,070	76,255	0	15,577	0	29,257	21.00
22.00	Unit cost multiplier	0.193007	22.329429	0.000000	4.561347	0.000000	8.567204	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151329 HHA CCN: 157143

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

Worksheet H-2 Part II Date/Time Prepared: 5/26/2016 11:49 am

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	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (100% PHARMACY)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	30,252	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	0	0	30,252	0	0	20.00
21.00	Total cost to be allocated	0	0	0	32	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.001058	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151329 | HHA CCN: 157143 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part I | Date/Time Prepared: 5/26/2016 11:49 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,210,193		1,210,193	5,012	241.46	1.00
2.00	Physical Therapy	3.00	945,527	0	945,527	2,896	326.49	2.00
3.00	Occupational Therapy	4.00	193,624	0	193,624	555	348.87	3.00
4.00	Speech Pathology	5.00	3,804	0	3,804	54	70.44	4.00
5.00	Medical Social Services	6.00	40,298		40,298	18	2,238.78	5.00
6.00	Home Health Aide	7.00	107,855		107,855	478	225.64	6.00
7.00	Total (sum of lines 1-6)		2,501,301	0	2,501,301	9,013		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		17140	0	0			8.00
8.01	Skilled Nursing Care		50031	0	1,864			8.01
8.02	Skilled Nursing Care		50034	0	353			8.02
8.03	Skilled Nursing Care		50035	0	687			8.03
8.04	Skilled Nursing Care		50042	0	11			8.04
8.05	Skilled Nursing Care		99915	0	0			8.05
9.00	Physical Therapy		17140	0	0			9.00
9.01	Physical Therapy		50031	0	940			9.01
9.02	Physical Therapy		50034	0	270			9.02
9.03	Physical Therapy		50035	0	474			9.03
9.04	Physical Therapy		50042	0	7			9.04
9.05	Physical Therapy		99915	0	0			9.05
10.00	Occupational Therapy		17140	0	0			10.00
10.01	Occupational Therapy		50031	0	229			10.01
10.02	Occupational Therapy		50034	0	26			10.02
10.03	Occupational Therapy		50035	0	85			10.03
10.04	Occupational Therapy		50042	0	7			10.04
10.05	Occupational Therapy		99915	0	0			10.05
11.00	Speech Pathology		17140	0	0			11.00
11.01	Speech Pathology		50031	0	19			11.01
11.02	Speech Pathology		50034	0	6			11.02
11.03	Speech Pathology		50035	0	21			11.03
11.04	Speech Pathology		50042	0	0			11.04
11.05	Speech Pathology		99915	0	0			11.05
12.00	Medical Social Services		17140	0	0			12.00
12.01	Medical Social Services		50031	0	8			12.01
12.02	Medical Social Services		50034	0	3			12.02
12.03	Medical Social Services		50035	0	2			12.03
12.04	Medical Social Services		50042	0	0			12.04
12.05	Medical Social Services		99915	0	0			12.05
13.00	Home Health Aide		17140	0	0			13.00
13.01	Home Health Aide		50031	0	181			13.01
13.02	Home Health Aide		50034	0	17			13.02
13.03	Home Health Aide		50035	0	165			13.03
13.04	Home Health Aide		50042	0	5			13.04
13.05	Home Health Aide		99915	0	0			13.05
14.00	Total (sum of lines 8-13)			0	5,380			14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151329 | HHA CCN: 157143 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part I | Date/Time Prepared: 5/26/2016 11:49 am

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	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total 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	0	0	0	30,252	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits			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	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	2,915		0	703,856		1.00
2.00	Physical Therapy	0	1,691		0	552,095		2.00
3.00	Occupational Therapy	0	347		0	121,058		3.00
4.00	Speech Pathology	0	46		0	3,240		4.00
5.00	Medical Social Services	0	13		0	29,104		5.00
6.00	Home Health Aide	0	368		0	83,036		6.00
7.00	Total (sum of lines 1-6)	0	5,380		0	1,492,389		7.00

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
8.03	Skilled Nursing Care							8.03
8.04	Skilled Nursing Care							8.04
8.05	Skilled Nursing Care							8.05
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
9.03	Physical Therapy							9.03
9.04	Physical Therapy							9.04
9.05	Physical Therapy							9.05
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
10.03	Occupational Therapy							10.03
10.04	Occupational Therapy							10.04
10.05	Occupational Therapy							10.05
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
11.03	Speech Pathology							11.03
11.04	Speech Pathology							11.04
11.05	Speech Pathology							11.05
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
12.03	Medical Social Services							12.03
12.04	Medical Social Services							12.04
12.05	Medical Social Services							12.05
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
13.03	Home Health Aide							13.03
13.04	Home Health Aide							13.04
13.05	Home Health Aide							13.05
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151329 HHA CCN: 157143 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part I Date/Time Prepared: 5/26/2016 11:49 am

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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	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	703,856	1.00
2.00	Physical Therapy	552,095	2.00
3.00	Occupational Therapy	121,058	3.00
4.00	Speech Pathology	3,240	4.00
5.00	Medical Social Services	29,104	5.00
6.00	Home Health Aide	83,036	6.00
7.00	Total (sum of lines 1-6)	1,492,389	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
8.02	Skilled Nursing Care		8.02
8.03	Skilled Nursing Care		8.03
8.04	Skilled Nursing Care		8.04
8.05	Skilled Nursing Care		8.05
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
9.02	Physical Therapy		9.02
9.03	Physical Therapy		9.03
9.04	Physical Therapy		9.04
9.05	Physical Therapy		9.05
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
10.02	Occupational Therapy		10.02
10.03	Occupational Therapy		10.03
10.04	Occupational Therapy		10.04
10.05	Occupational Therapy		10.05
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
11.02	Speech Pathology		11.02
11.03	Speech Pathology		11.03
11.04	Speech Pathology		11.04
11.05	Speech Pathology		11.05
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
12.02	Medical Social Services		12.02
12.03	Medical Social Services		12.03
12.04	Medical Social Services		12.04
12.05	Medical Social Services		12.05
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
13.02	Home Health Aide		13.02
13.03	Home Health Aide		13.03
13.04	Home Health Aide		13.04
13.05	Home Health Aide		13.05
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151329 HHA CCN: 157143 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part II Date/Time Prepared: 5/26/2016 11:49 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.583741	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.592930	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.900424	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.427661	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.327586	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/26/2016 11:49 am

HHA CCN: 157143 | Title XVIII | Home Health Agency I | PPS

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	917,254	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	4,495	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	15,741	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	11,842	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	68	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	949,400	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	949,400	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	949,400	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	949,400	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	949,400	31.00
31.01	Sequestration adjustment (see instructions)	0	18,988	31.01
32.00	Interim payments (see instructions)	0	930,411	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: 151329 HHA CCN: 157143 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-5 Date/Time Prepared: 5/26/2016 11:49 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		930,411	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		930,411	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		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		930,412	7.00

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

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151329 Hospice CCN: 151551 | Period: From 01/01/2015 To 12/31/2015 | Worksheet K | Date/Time Prepared: 5/26/2016 11:49 am

Hospice I

		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	165,494	0	366	0	282,887	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	300,676	0	37,722	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	58,532	0	6,405	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	84,812	0	22,266	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	24,667	0	2,462	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	634,181	0	69,221	0	282,887	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151329 Hospice CCN: 151551 | Period: From 01/01/2015 To 12/31/2015 | Worksheet K | Date/Time Prepared: 5/26/2016 11:49 am

Hospice I

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	448,747	0	448,747	0	448,747	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	338,398	0	338,398	0	338,398	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	64,937	0	64,937	0	64,937	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	107,078	0	107,078	0	107,078	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	27,129	0	27,129	0	27,129	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	986,289	0	986,289	0	986,289	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151329 Hospice CCN: 151551

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

Worksheet K-1

Date/Time Prepared: 5/26/2016 11:49 am

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	165,494	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	300,676	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	58,532	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	165,494	58,532	0	300,676	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151329 Hospice CCN: 151551

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

Worksheet K-1

Date/Time Prepared: 5/26/2016 11:49 am

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	165,494		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	0	300,676		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	58,532		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		84,812	0	84,812		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	24,667	24,667		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	84,812	24,667	634,181		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151329 Hospice CCN: 151551

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

Worksheet K-4 Part I Date/Time Prepared: 5/26/2016 11:49 am

Hospice I

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	448,747	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	338,398	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	64,937	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	107,078	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	27,129	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	986,289	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151329 Hospice CCN: 151551

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

Worksheet K-4 Part I Date/Time Prepared: 5/26/2016 11:49 am

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance						3.00
4.00	Transportation - Staff						4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	448,747	448,747			6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0		7.00
8.00	Inpatient - Respite Care	0	0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0		9.00
10.00	Nursing Care	0	338,398	282,499	620,897		10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services	0	64,937	54,210	119,147		15.00
16.00	Spiritual Counseling	0	0	0	0		16.00
17.00	Dietary Counseling	0	0	0	0		17.00
18.00	Counseling - Other	0	0	0	0		18.00
19.00	Home Health Aide and Homemaker	0	107,078	89,390	196,468		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		20.00
21.00	Other	0	27,129	22,648	49,777		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0		22.00
23.00	Analgesics	0	0	0	0		23.00
24.00	Sedatives / Hypnotics	0	0	0	0		24.00
25.00	Other - Specify	0	0	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0		26.00
27.00	Patient Transportation	0	0	0	0		27.00
28.00	Imaging Services	0	0	0	0		28.00
29.00	Labs and Diagnostics	0	0	0	0		29.00
30.00	Medical Supplies	0	0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0		31.00
32.00	Radiation Therapy	0	0	0	0		32.00
33.00	Chemotherapy	0	0	0	0		33.00
34.00	Other	0	0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0		35.00
36.00	Volunteer Program Costs	0	0	0	0		36.00
37.00	Fundraising	0	0	0	0		37.00
38.00	Other Program Costs	0	0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	986,289		986,289		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151329 Hospice CCN: 151551 | Period: From 01/01/2015 To 12/31/2015 | Worksheet K-4 Part II Date/Time Prepared: 5/26/2016 11:49 am

Hospice I

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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151329 Hospice CCN: 151551 | Period: From 01/01/2015 To 12/31/2015 | Worksheet K-4 Part II Date/Time Prepared: 5/26/2016 11:49 am

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)		
		6A	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0			1.00
2.00	Capital Related Costs-Movable Equip.	0			2.00
3.00	Plant Operation and Maintenance	0			3.00
4.00	Transportation - Staff	0			4.00
5.00	Volunteer Service Coordination				5.00
6.00	Administrative and General	-448,747	537,542		6.00
	INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0		7.00
8.00	Inpatient - Respite Care	0	0		8.00
	VISITING SERVICES				
9.00	Physician Services	0	0		9.00
10.00	Nursing Care	0	338,398		10.00
11.00	Nursing Care-Continuous Home Care	0	0		11.00
12.00	Physical Therapy	0	0		12.00
13.00	Occupational Therapy	0	0		13.00
14.00	Speech/ Language Pathology	0	0		14.00
15.00	Medical Social Services	0	64,937		15.00
16.00	Spiritual Counseling	0	0		16.00
17.00	Dietary Counseling	0	0		17.00
18.00	Counseling - Other	0	0		18.00
19.00	Home Health Aide and Homemaker	0	107,078		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		20.00
21.00	Other	0	27,129		21.00
	OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0		22.00
23.00	Analgesics	0	0		23.00
24.00	Sedatives / Hypnotics	0	0		24.00
25.00	Other - Specify	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0		26.00
27.00	Patient Transportation	0	0		27.00
28.00	Imaging Services	0	0		28.00
29.00	Labs and Diagnostics	0	0		29.00
30.00	Medical Supplies	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		31.00
32.00	Radiation Therapy	0	0		32.00
33.00	Chemotherapy	0	0		33.00
34.00	Other	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0		35.00
36.00	Volunteer Program Costs	0	0		36.00
37.00	Fundraising	0	0		37.00
38.00	Other Program Costs	0	0		38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		448,747		39.00
40.00	Unit Cost Multiplier		0.834813		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151329 Hospice CCN: 151551

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

Worksheet K-5 Part I Date/Time Prepared: 5/26/2016 11:49 am

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS				
			NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	
		0	1.00	1.01	2.00	2.01	
1.00	Administrative and General		0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	620,897	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	119,147	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	196,468	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	49,777	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	986,289	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151329 Hospice CCN: 151551

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

Worksheet K-5 Part I Date/Time Prepared: 5/26/2016 11:49 am

Hospice I

	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
		4.00	4A	5.00	7.00	7.01	
1.00	Administrative and General	230,409	230,409	44,471	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	620,897	119,837	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	119,147	22,996	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	196,468	37,920	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	49,777	9,607	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	230,409	1,216,698	234,831	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)		0.000000				35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151329
Hospice CCN: 151551

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

Worksheet K-5
Part I
Date/Time Prepared:
5/26/2016 11:49 am

Hospice I

	Cost Center Description	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.02	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151329 Hospice CCN: 151551

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

Worksheet K-5 Part I Date/Time Prepared: 5/26/2016 11:49 am

Hospice I

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal (cols. 4A-23)	
		13.00	14.00	15.00	16.00	24.00	
1.00	Administrative and General	0	14	0	0	274,894	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	740,734	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	142,143	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	234,388	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	59,384	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	14	0	0	1,451,543	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151329 Hospice CCN: 151551

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

Worksheet K-5 Part I Date/Time Prepared: 5/26/2016 11:49 am

Hospice I

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)		
		25.00	26.00	27.00	28.00		
1.00	Administrative and General						1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	0	0	0		4.00
5.00	Nursing Care	0	740,734	173,053	913,787		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00	Physical Therapy	0	0	0	0		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	142,143	33,208	175,351		10.00
11.00	Spiritual Counseling	0	0	0	0		11.00
12.00	Dietary Counseling	0	0	0	0		12.00
13.00	Counseling - Other	0	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	234,388	54,759	289,147		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00	Other	0	59,384	13,874	73,258		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00	Analgesics	0	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0	0		19.00
20.00	Other - Specify	0	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00	Patient Transportation	0	0	0	0		22.00
23.00	Imaging Services	0	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0	0		24.00
25.00	Medical Supplies	0	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00	Radiation Therapy	0	0	0	0		27.00
28.00	Chemotherapy	0	0	0	0		28.00
29.00	Other	0	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0	0		31.00
32.00	Fundraising	0	0	0	0		32.00
33.00	Other Program Costs	0	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	1,451,543		1,451,543		34.00
35.00	Unit Cost Multiplier (see instructions)			0.233624			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151329
Hospice CCN: 151551

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

Worksheet K-5
Part II
Date/Time Prepared:
5/26/2016 11:49 am

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		1.00	1.01	2.00	2.01	4.00	
1.00	Administrative and General	0	3,750	0	0	634,181	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	3,750	0	0	634,181	34.00
35.00	Total cost to be allocated	0	0	0	0	230,409	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000	0.363317	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151329
Hospice CCN: 151551

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

Worksheet K-5
Part II
Date/Time Prepared:
5/26/2016 11:49 am

Hospice I

	Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	
		5A	5.00	7.00	7.01	7.02	
1.00	Administrative and General	0	230,409	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	620,897	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	119,147	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	196,468	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	49,777	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)		1,216,698	0	0	0	34.00
35.00	Total cost to be allocated		234,831	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)		0.193007	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151329
Hospice CCN: 151551

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

Worksheet K-5
Part II
Date/Time Prepared:
5/26/2016 11:49 am

Hospice I

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151329
Hospice CCN: 151551

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

Worksheet K-5
Part II
Date/Time Prepared:
5/26/2016 11:49 am

Hospice I

	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (100% PHARMACY)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
		14.00	15.00	16.00		
1.00	Administrative and General	124,567	0	0		1.00
2.00	Inpatient - General Care	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0		3.00
4.00	Physician Services	0	0	0		4.00
5.00	Nursing Care	0	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0		6.00
7.00	Physical Therapy	0	0	0		7.00
8.00	Occupational Therapy	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0		9.00
10.00	Medical Social Services	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0		11.00
12.00	Dietary Counseling	0	0	0		12.00
13.00	Counseling - Other	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0		15.00
16.00	Other	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0		17.00
18.00	Analgesics	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0		19.00
20.00	Other - Specify	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0		21.00
22.00	Patient Transportation	0	0	0		22.00
23.00	Imaging Services	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0		24.00
25.00	Medical Supplies	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0		26.00
27.00	Radiation Therapy	0	0	0		27.00
28.00	Chemotherapy	0	0	0		28.00
29.00	Other	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0		31.00
32.00	Fundraising	0	0	0		32.00
33.00	Other Program Costs	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	124,567	0	0		34.00
35.00	Total cost to be allocated	14	0	0		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000112	0.000000	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 151329 Hospice CCN: 151551

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

Worksheet K-5 Part III Date/Time Prepared: 5/26/2016 11:49 am

Hospice I

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.583741	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.592930	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.900424	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.327586	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.213461	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.427661	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00				10.00
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 151329 | Hospice CCN: 151551 | Period: From 01/01/2015 To 12/31/2015 | Worksheet K-6 | Date/Time Prepared: 5/26/2016 11:49 am

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				1,451,543	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				11,832	2.00
3.00	Average cost per diem (line 1 divided by line 2)				122.68	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	10,949				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	1,343,223				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		84			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		10,305			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	5,507				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	675,599				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			799		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			98,021		13.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 151329 | Component CCN: 158511 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/26/2016 11:49 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	170,519	0	170,519	0	170,519	1.00
2.00	Physician Assistant	118,132	0	118,132	0	118,132	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	16,062	0	16,062	0	16,062	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	59,480	0	59,480	0	59,480	9.00
10.00	Subtotal (sum of lines 1 through 9)	364,193	0	364,193	0	364,193	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	364,193	0	364,193	0	364,193	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	76,240	76,240	0	76,240	29.00
30.00	Administrative Costs	139,523	0	139,523	0	139,523	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	139,523	76,240	215,763	0	215,763	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	503,716	76,240	579,956	0	579,956	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 151329 | Component CCN: 158511 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/26/2016 11:49 am

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	170,519		1.00
2.00	Physician Assistant	0	118,132		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	16,062		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	59,480		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	364,193		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	364,193		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	76,240		29.00
30.00	Administrative Costs	0	139,523		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	215,763		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	579,956		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 151329 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-2

Component CCN: 158511 | Date/Time Prepared: 5/26/2016 11:49 am

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.62	2,766	4,200	2,604		1.00
2.00	Physician Assistant	0.86	1,343	2,100	1,806		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.48	4,109		4,410	4,410	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.48	4,109			4,410	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					364,193	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					364,193	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					215,763	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					460,672	15.00
16.00	Total overhead (sum of lines 14 and 15)					676,435	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					676,435	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					676,435	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,040,628	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 151329 Component CCN: 158511	Period: From 01/01/2015 To 12/31/2015	Worksheet M-3 Date/Time Prepared: 5/26/2016 11:49 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		1,040,628	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		110,071	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		930,557	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,410	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,410	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		211.01	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	80.44	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	211.01	211.01	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,277	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	269,460	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		269,460	16.00
16.01	Total program charges (see instructions)(from contractor's records)		165,291	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,770	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,516	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		197,981	16.04
16.05	Total program cost (see instructions)		202,497	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		17,468	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		29,011	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		202,497	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		64,008	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		266,505	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		266,505	26.00
26.01	Sequestration adjustment (see instructions)		5,330	26.01
27.00	Interim payments		187,117	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		74,058	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 151329 Component CCN: 158511	Period: From 01/01/2015 To 12/31/2015	Worksheet M-4 Date/Time Prepared: 5/26/2016 11:49 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	364,193	364,193	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.006801	0.013813	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2,477	5,031	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	19,982	11,032	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	22,459	16,063	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	364,193	364,193	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	676,435	676,435	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.061668	0.044106	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	41,714	29,835	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	64,173	45,898	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	97	197	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	661.58	232.98	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	64	93	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	42,341	21,667	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		110,071	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		64,008	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151329 Component CCN: 158511	Period: From 01/01/2015 To 12/31/2015	Worksheet M-5 Date/Time Prepared: 5/26/2016 11:49 am
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		187,117	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	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	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		187,117	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	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		74,058	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		261,175	7.00

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