Health Financial Systems | PERRY COUNTY HOSPITAL | In Lieu of Form CMS-2552-10

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151322	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/24/2016 9:34 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/24/2016 Time: 9:34 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 PERRY COUNTY HOSPITAL (151322) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/24/2016 Time: 9:34 am
huPTXOOwH6qzxW3Ow3zfy:V3rwiw.0
C6wrrOukHFo1:Md1O3N2SSsCobjx1x
DRnN1yQudLOKq4ce

PI: Date: 5/24/2016 Time: 9:34 am
co.14vd5zuW7V4UtsiXRKLe1J8hfKO
nNMR6OnVimCutHf3:QnQRP2t5JSIpB
mZ4ZO5grvqOMO9fL

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

CFO
Title

5/26/16
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-45,481	230,150	1	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-8,047	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	-647		0	9.00
10.00	RURAL HEALTH CLINIC - TELL CITY I	0		76,260		0	10.00
10.01	RURAL HEALTH CLINIC - PERRY CO FP II	0		6,453		0	10.01
10.02	RURAL HEALTH CLINIC - TROY III	0		0		0	10.02
200.00	Total	0	-53,528	312,216	1	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2016 9:32 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: ONE HOSPITAL ROAD	PO Box: X			1.00
2.00	City: TELL CITY	State: IN	Zip Code: 47856-	County: PERRY	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	PERRY COUNTY HOSPITAL	151322	99915	1	07/01/2004	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PERRY COUNTY HOSPITAL SWING	15Z322	99915		07/01/2004	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	PERRY COUNTY HOSPITAL HHA	157177	99915		06/13/1986	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	TELL CITY CLINIC	158516	99915		05/18/2015	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	PERRY CO FAMILY PRACTICE	158517	99915		05/19/2015	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	TROY CLINIC	158518	99915		11/23/2015	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2015	12/31/2015	20.00
21.00	Type of Control (see instructions)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02

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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	

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		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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
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.	Y	Y	Y	N	109.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	118.01

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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)	Y		140.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2016 9:32 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)	1	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: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2016 9:32 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	05/01/2013	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	03/08/2016	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: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 5/24/2016 9:32 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.				N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RICH	FERRIELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923832	RFERRIELL@ALLIANTMANAGEMENT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 5/24/2016 9:32 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)	03/08/2016			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/24/2016 9:32 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	54,072.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	54,072.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	4,992.00	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	59,064.00	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 - TELL CITY	88.00				0	26.00
26.01	RURAL HEALTH CLINIC - PERRY CO FP	88.01				0	26.01
26.02	RURAL HEALTH CLINIC - TROY	88.02				0	26.02
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: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2016 9:32 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,450	161	2,253			1.00
2.00	HMO and other (see instructions)	184	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	824	0	824			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		89	89			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,274	250	3,166			7.00
8.00	INTENSIVE CARE UNIT	89	0	208			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		179	179			13.00
14.00	Total (see instructions)	2,363	429	3,553	0.00	237.27	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,718	1,010	5,923	0.00	6.81	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC - TELL CITY	1,664	0	5,229	0.00	14.30	26.00
26.01	RURAL HEALTH CLINIC - PERRY CO FP	63	0	1,148	0.00	2.52	26.01
26.02	RURAL HEALTH CLINIC - TROY	0	0	169	0.00	0.42	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	261.32	27.00
28.00	Observation Bed Days		0	420			28.00
29.00	Ambulance Trips	869					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: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2016 9:32 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	442	60	783	1.00
2.00	HMO and other (see instructions)			35	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	442	60	783	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 - TELL CITY	0.00					26.00
26.01	RURAL HEALTH CLINIC - PERRY CO FP	0.00					26.01
26.02	RURAL HEALTH CLINIC - TROY	0.00					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part IV Date/Time Prepared: 5/24/2016 9:32 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	532,922	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2,976,066	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	37,296	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	39,085	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	120,296	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	898,167	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,603,832	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 151322 | Component CCN: 157177 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-4 | Date/Time Prepared: 5/24/2016 9:32 am

Home Health Agency I | PPS

		1.00	
0.00	County	PERRY	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	124.00	0.00	50.00	174.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		0.00	0.00	0.00	5.00
6.00	Direct Nursing Service		0.00	0.00	0.00	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		15999			20.00

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	987	52	50	11	1,100	21.00
22.00	Skilled Nursing Visit Charges	405,896	21,216	20,384	4,488	451,984	22.00
23.00	Physical Therapy Visits	837	23	2	0	862	23.00
24.00	Physical Therapy Visit Charges	247,476	6,808	592	0	254,876	24.00
25.00	Occupational Therapy Visits	603	16	1	0	620	25.00
26.00	Occupational Therapy Visit Charges	155,430	4,128	258	0	159,816	26.00
27.00	Speech Pathology Visits	14	0	0	0	14	27.00
28.00	Speech Pathology Visit Charges	4,089	0	0	0	4,089	28.00
29.00	Medical Social Service Visits	6	0	0	0	6	29.00
30.00	Medical Social Service Visit Charges	2,022	0	0	0	2,022	30.00
31.00	Home Health Aide Visits	103	13	0	0	116	31.00
32.00	Home Health Aide Visit Charges	21,930	2,782	0	0	24,712	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,550	104	53	11	2,718	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)	836,843	34,934	21,234	4,488	897,499	35.00
36.00	Total Number of Episodes (standard/non outlier)	129		21	2	152	36.00
37.00	Total Number of Outlier Episodes		2		0	2	37.00
38.00	Total Non-Routine Medical Supply Charges	42,616	2,366	1,960	497	47,439	38.00

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

Provider CCN: 151322 Component CCN: 158516 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-8 Date/Time Prepared: 5/24/2016 9:32 am

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	109 IN-66	1.00
		City: 1.00	State: 2.00	ZIP Code: 3.00
2.00	City, State, ZIP Code, County	TELL CITY	IN	47586	2.00
			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00
		Grant Award: 1.00	Date: 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: 1.00	to: 2.00	from: 3.00	to: 4.00	from: 5.00	
	Facility hours of operations (1)						
11.00	Clinic			06:30	17:00	06:30	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			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: 1.00	CCN number: 2.00	
14.00	Provider name, CCN number			14.00

		Y/N: 1.00	V: 2.00	XVIII: 3.00	XIX: 4.00	Total Visits: 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		PERRY				2.00
		Tuesday: to 6.00	Wednesday: from 7.00	to 8.00	Thursday: from 9.00	to 10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	06:30	17:00	06:30	17:00	11.00

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

Provider CCN: 151322
Component CCN: 158516

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

Worksheet S-8
Date/Time Prepared:
5/24/2016 9:32 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	06:30	16:00				11.00

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

Provider CCN: 151322 Component CCN: 158517 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-8 Date/Time Prepared: 5/24/2016 9:32 am

		Rural Health Clinic (RHC) II	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	315 MAIN STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	TROY	IN	47588	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	17:00	08:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			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		PERRY				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	17:00	10:00	19:00	08:00	17:00	11.00

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

Provider CCN: 151322
Component CCN: 158517

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

Worksheet S-8
Date/Time Prepared:
5/24/2016 9:32 am

Rural Health Clinic (RHC) II

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

Provider CCN: 151322 | Component CCN: 158518 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-8 | Date/Time Prepared: 5/24/2016 9:32 am

Rural Health Clinic (RHC) III | Cost

					1.00		
	Clinic Address and Identification						
1.00	Street				18485 OLD STATE ROAD 37		1.00
		City			State	ZIP Code	
		1.00			2.00	3.00	
2.00	City, State, ZIP Code, County	LEOPOLD			IN	47551	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			07:00	16:00	07:00	11.00

					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?						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		PERRY				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	16:00	07:00	11:00	07:00	16:00	11.00

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

Provider CCN: 151322
Component CCN: 158518

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

Worksheet S-8

Date/Time Prepared:
5/24/2016 9:32 am

Rural Health Clinic (RHC) III

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	07:00	15:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151322	Period: From 01/01/2015 To 12/31/2015	Worksheet S-10 Date/Time Prepared: 5/24/2016 9:32 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.398181	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,418,047	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	13,441,811	6.00
7.00	Medicaid cost (line 1 times line 6)	5,352,274	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)	2,934,227	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)	2,934,227	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	805,741	0	805,741	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	320,831	0	320,831	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)	320,831	0	320,831	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?		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)	4,781,927	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	338,844	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,443,083	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,769,151	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,089,982	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,024,209	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/24/2016 9:32 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,002,455	1,002,455	131,054	1,133,509	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	820,685	820,685	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	126,054	4,445,172	4,571,226	-4,369,874	201,352	4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	501,264	2,432,564	2,933,828	85,193	3,019,021	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	1,453,559	1,310,818	2,764,377	394,096	3,158,473	5.02
7.00	00700	OPERATION OF PLANT	302,068	1,010,697	1,312,765	94,044	1,406,809	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	847	84,724	85,571	21	85,592	8.00
9.00	00900	HOUSEKEEPING	205,429	66,724	272,153	211,945	484,098	9.00
10.00	01000	DIETARY	37,780	582,130	619,910	-377,382	242,528	10.00
11.00	01100	CAFETERIA	0	0	0	408,435	408,435	11.00
13.00	01300	NURSING ADMINISTRATION	579,492	10,889	590,381	89,127	679,508	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	191,679	158,520	350,199	17,206	367,405	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,445,336	728,834	2,174,170	486,940	2,661,110	30.00
31.00	03100	INTENSIVE CARE UNIT	258,549	12,471	271,020	28,659	299,679	31.00
43.00	04300	NURSERY	54,786	0	54,786	396	55,182	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	413,207	502,273	915,480	115,896	1,031,376	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53,189	0	53,189	385	53,574	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	878,879	668,560	1,547,439	187,191	1,734,630	54.00
60.00	06000	LABORATORY	626,177	998,791	1,624,968	268,604	1,893,572	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,387	106,514	116,901	74	116,975	62.00
65.00	06500	RESPIRATORY THERAPY	496,250	284,194	780,444	361,149	1,141,593	65.00
66.00	06600	PHYSICAL THERAPY	23,979	444,179	468,158	4,486	472,644	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	188,745	188,745	0	188,745	67.00
68.00	06800	SPEECH PATHOLOGY	0	122,181	122,181	0	122,181	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,862	325,104	367,966	-37,927	330,039	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	111,063	111,063	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	79,689	2,241,009	2,320,698	50,734	2,371,432	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	779,852	449,376	1,229,228	212,212	1,441,440	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	124,912	115,046	239,958	41,461	281,419	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	20,940	15,135	36,075	15,853	51,928	88.02
90.00	09000	CLINIC	261,964	59,939	321,903	249,846	571,749	90.00
90.01	09001	PAIN MANAGEMENT	83,814	18,784	102,598	6,267	108,865	90.01
91.00	09100	EMERGENCY	832,124	1,751,802	2,583,926	538,986	3,122,912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	514,380	308,626	823,006	-3,914	819,092	95.00
101.00	10100	HOME HEALTH AGENCY	294,527	307,870	602,397	82,166	684,563	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		3,060	3,060	-776,812	-773,752	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,693,975	20,757,186	31,451,161	-551,735	30,899,426	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,412,303	1,198,686	3,610,989	557,118	4,168,107	192.00
192.01	19201	MARKETING	16,909	262,665	279,574	-5,383	274,191	192.01
200.00		TOTAL (SUM OF LINES 118-199)	13,123,187	22,218,537	35,341,724	0	35,341,724	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/24/2016 9:32 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-256,747	876,762		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	862,273	1,682,958		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	201,352		4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	-828,347	2,190,674		5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	3,158,473		5.02
7.00	00700	OPERATION OF PLANT	-8,051	1,398,758		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	85,592		8.00
9.00	00900	HOUSEKEEPING	0	484,098		9.00
10.00	01000	DIETARY	-128	242,400		10.00
11.00	01100	CAFETERIA	-95,676	312,759		11.00
13.00	01300	NURSING ADMINISTRATION	0	679,508		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,759	362,646		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,661,110		30.00
31.00	03100	INTENSIVE CARE UNIT	0	299,679		31.00
43.00	04300	NURSERY	0	55,182		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-111,987	919,389		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	53,574		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-77,628	1,657,002		54.00
60.00	06000	LABORATORY	0	1,893,572		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	116,975		62.00
65.00	06500	RESPIRATORY THERAPY	-180,094	961,499		65.00
66.00	06600	PHYSICAL THERAPY	0	472,644		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	188,745		67.00
68.00	06800	SPEECH PATHOLOGY	0	122,181		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-9,653	320,386		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	111,063		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,879	2,368,553		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	0	1,441,440		88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0	281,419		88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0	51,928		88.02
90.00	09000	CLINIC	0	571,749		90.00
90.01	09001	PAIN MANAGEMENT	0	108,865		90.01
91.00	09100	EMERGENCY	-1,335,541	1,787,371		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-8,355	810,737		95.00
101.00	10100	HOME HEALTH AGENCY	-283	684,280		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	773,752	0		113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,284,103	29,615,323		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,168,107		192.00
192.01	19201	MARKETING	0	274,191		192.01
200.00		TOTAL (SUM OF LINES 118-199)	-1,284,103	34,057,621		200.00

RECLASSIFICATIONS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/24/2016 9:32 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETRIA COST				
1.00	CAFETERIA	11.00	24,861	383,064	1.00
	TOTALS		24,861	383,064	
	B - INTEREST EXPENSE				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	778,614	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	778,614	
	C - LEASE EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	131,054	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
	TOTALS		0	131,054	
	D - INSURANCE EXPENSE				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	42,071	1.00
	TOTALS		0	42,071	
	G - DRUGS CHARGED				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	87,034	1.00
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
	TOTALS		0	87,034	
	J - BILLABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	71,782	1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,046	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
6.00		0.00	0	0	6.00
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
	TOTALS		0	72,828	
	M - YELLOW PAGES				
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	14,362	1.00
	TOTALS		0	14,362	
	P - IMPLANTABLE DEVICE				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	110,017	1.00
	TOTALS		0	110,017	
	R - PAYROLL				
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	115,070	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	398,078	2.00
3.00	OPERATION OF PLANT	7.00	0	96,272	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	21	4.00
5.00	HOUSEKEEPING	9.00	0	211,945	5.00
6.00	DIETARY	10.00	0	30,543	6.00
7.00	CAFETERIA	11.00	0	510	7.00
8.00	NURSING ADMINISTRATION	13.00	0	89,127	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	45,684	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	493,058	10.00
11.00	INTENSIVE CARE UNIT	31.00	0	29,014	11.00
12.00	NURSERY	43.00	0	396	12.00
13.00	OPERATING ROOM	50.00	0	154,554	13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	385	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	188,902	15.00
16.00	LABORATORY	60.00	0	268,604	16.00

RECLASSIFICATIONS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/24/2016 9:32 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
17.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	74		17.00
18.00	RESPIRATORY THERAPY	65.00	0	391,089		18.00
19.00	PHYSICAL THERAPY	66.00	0	5,424		19.00
20.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	308		20.00
21.00	DRUGS CHARGED TO PATIENTS	73.00	0	22,065		21.00
22.00	RURAL HEALTH CLINIC - TELL CITY	88.00	0	212,212		22.00
23.00	RURAL HEALTH CLINIC - PERRY CO FP	88.01	0	41,461		23.00
24.00	RURAL HEALTH CLINIC - TROY	88.02	0	15,853		24.00
25.00	CLINIC	90.00	0	250,139		25.00
26.00	PAIN MANAGEMENT	90.01	0	6,300		26.00
27.00	EMERGENCY	91.00	0	560,363		27.00
28.00	HOME HEALTH AGENCY	101.00	0	85,314		28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	650,859		29.00
30.00	MARKETING	192.01	0	8,979		30.00
	TOTALS		0	4,372,603		
500.00	Grand Total: Increases		24,861	5,991,647		500.00

RECLASSIFICATIONS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/24/2016 9:32 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETRIA COST						
1.00	DIETARY	10.00	24,861	383,064	0		1.00
	TOTALS		24,861	383,064			
	B - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	776,812	11		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,802	0		2.00
	TOTALS		0	778,614			
	C - LEASE EXPENSE						
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	100	9		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	3,982	0		2.00
3.00	OPERATION OF PLANT	7.00	0	2,228	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	28,478	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	2,035	0		5.00
6.00	OPERATING ROOM	50.00	0	25	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	528	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	29,940	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	152	0		9.00
10.00	DRUGS CHARGED TO PATIENTS	73.00	0	58,348	0		10.00
11.00	EMERGENCY	91.00	0	236	0		11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,002	0		12.00
	TOTALS		0	131,054			
	D - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	42,071	10		1.00
	TOTALS		0	42,071			
	G - DRUGS CHARGED						
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	2,068	0		1.00
4.00	EMERGENCY	91.00	0	18,378	0		4.00
5.00	HOME HEALTH AGENCY	101.00	0	427	0		5.00
6.00	PAIN MANAGEMENT	90.01	0	33	0		6.00
7.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	66,128	0		7.00
	TOTALS		0	87,034			
	J - BILLABLE SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	4,083	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	355	0		2.00
3.00	OPERATING ROOM	50.00	0	38,633	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,183	0		4.00
6.00	PHYSICAL THERAPY	66.00	0	786	0		6.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	17	0		8.00
9.00	CLINIC	90.00	0	293	0		9.00
10.00	EMERGENCY	91.00	0	2,763	0		10.00
11.00	AMBULANCE SERVICES	95.00	0	1,185	0		11.00
12.00	HOME HEALTH AGENCY	101.00	0	2,721	0		12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	20,809	0		13.00
	TOTALS		0	72,828			
	M - YELLOW PAGES						
1.00	MARKETING	192.01	0	14,362	0		1.00
	TOTALS		0	14,362			
	P - IMPLANTABLE DEVICE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	110,017	0		1.00
	TOTALS		0	110,017			
	R - PAYROLL						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,369,874	0		1.00
2.00	AMBULANCE SERVICES	95.00	0	2,729	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00

RECLASSIFICATIONS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/24/2016 9:32 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
	TOTALS		0	4,372,603			
500.00	Grand Total: Decreases		24,861	5,991,647			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 5/24/2016 9:32 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,945,631	0	0	0	0	1.00
2.00	Land Improvements	1,494,906	0	0	0	0	2.00
3.00	Buildings and Fixtures	10,365,854	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	10,682,160	6,132,859	0	6,132,859	0	5.00
6.00	Movable Equipment	11,100,348	471,756	0	471,756	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	36,588,899	6,604,615	0	6,604,615	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	36,588,899	6,604,615	0	6,604,615	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,945,631	0	1.00
2.00	Land Improvements	1,494,906	0	2.00
3.00	Buildings and Fixtures	10,365,854	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	16,815,019	0	5.00
6.00	Movable Equipment	11,572,104	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	43,193,514	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	43,193,514	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/24/2016 9:32 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,002,455	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,002,455	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,002,455	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	1,002,455	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/24/2016 9:32 am

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

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	876,762	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	881,796	22,548	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,758,558	22,548	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	876,762	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	778,614	0	0	0	1,682,958	2.00
3.00	Total (sum of lines 1-2)	778,614	0	0	0	2,559,720	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/24/2016 9:32 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-20,744	NEW CAP REL COSTS-MVBLE EQUIP	2.00	10	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-1,699,144			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,950,663			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-95,676	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-9,653	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-2,879	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,759	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-254,883	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/24/2016 9:32 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	MISC INCOME	B	-23,829	ADMINISTRATIVE AND GENERAL	5.01	0	33.00
33.01			0		0.00	0	33.01
34.00	MISC INCOME	B	-8,355	AMBULANCE SERVICES	95.00	0	34.00
35.00			0		0.00	0	35.00
36.00	HHA ADVERTISING	A	-283	HOME HEALTH AGENCY	101.00	0	36.00
37.00	RECRUITING	A	-112,562	ADMINISTRATIVE AND GENERAL	5.01	0	37.00
38.00			0		0.00	0	38.00
39.00	OLD BUILDING DEPRECIATION	A	-300,000	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	39.00
40.00	PHONE	A	-8,051	OPERATION OF PLANT	7.00	0	40.00
41.00	PHONE	A	-1,864	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	41.00
42.00	DIETARY	B	-128	DIETARY	10.00	0	42.00
43.00	AHA	A	-3,748	ADMINISTRATIVE AND GENERAL	5.01	0	43.00
45.00	NON-ALLOWABLE EXPENSE	A	-28,486	ADMINISTRATIVE AND GENERAL	5.01	0	45.00
45.01			0		0.00	0	45.01
45.02	MISCELLANEOUS EXPENSE	A	-5,322	ADMINISTRATIVE AND GENERAL	5.01	0	45.02
45.03	HAF FEES	A	-654,400	ADMINISTRATIVE AND GENERAL	5.01	0	45.03
45.04			0		0.00	0	45.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,284,103				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2016 9:32 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	AMBULANCE DEPRECIATION	1,221	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	MOBILE MRI	146,449	152,555	2.00
3.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	PERRY CO. MEMORIAL ASSOCIATI	1,181,796	0	3.00
4.00	113.00	INTEREST EXPENSE	PERRY CO. MEMORIAL ASSOCIATI	773,752	0	4.00
5.00	0		0	2,103,218	152,555	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B	PERRY CO AMBULA	100.00		0.00	6.00
7.00	B	DSSI	100.00		0.00	7.00
8.00	B	PERRY CO ASSOCI	100.00		0.00	8.00
9.00	B	PERRY CO ASSOCI	100.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	OTHER				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 151322	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-1 Date/Time Prepared: 5/24/2016 9:32 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,221	10		1.00
2.00	-6,106	0		2.00
3.00	1,181,796	9		3.00
4.00	773,752	11		4.00
5.00	1,950,663			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2016 9:32 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	111,987	111,987	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	71,522	71,522	0	0	0	2.00
3.00	60.00	LABORATORY	16,500	0	16,500	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	180,094	180,094	0	0	0	4.00
5.00	91.00	EMERGENCY	1,680,583	1,335,541	345,042	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,060,686	1,699,144	361,542		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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	0	0	111,987		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	71,522		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	180,094		4.00
5.00	91.00	EMERGENCY	0	0	0	1,335,541		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,699,144		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/24/2016 9:32 am

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					333	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					7	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					316	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					695	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	1,069.00	2,017.00	6,840.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	96.00	72.00	54.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.00	36.00	27.00			11.00
12.00	Number of travel hours (provider site)	0	121	177			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	4,859	7,091			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					102,624	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					145,224	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					369,360	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					617,208	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					617,208	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					617,208	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					11,988	24.00
25.00	Assistants (line 4 times column 3, line 11)					189	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					12,177	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,870	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					14,047	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					8,712	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					9,558	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					18,270	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					18,270	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					11,376	36.00
37.00	Assistants (line 6 times column 3, line 11)					18,765	37.00
38.00	Subtotal (sum of lines 36 and 37)					30,141	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					5,561	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/24/2016 9:32 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.00	54.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	617,208		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	18,270		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	9,580		61.00
62.00	Supplies (see instructions)	8,941		62.00
63.00	Total allowance (sum of lines 57-62)	653,999		63.00
64.00	Total cost of outside supplier services (from your records)	486,413		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	12,177		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,870		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	14,047		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,870		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	18,270		101.01
101.02	Line 34 = sum of lines 27 and 31	20,140		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	18,270		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	18,270		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151322	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/24/2016 9:32 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		254	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		2	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		241	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		436	6.00
7.00	Standard travel expense rate		5.50	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	3,352.00	1,714.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	68.25	51.19	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.13	34.13	25.60			11.00
12.00	Number of travel hours (provider site)	0	60	144			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	2,410	5,758			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	228,774	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	87,740	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	316,514	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	316,514	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	316,514	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	8,669	24.00
25.00	Assistants (line 4 times column 3, line 11)	51	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	8,720	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,408	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	10,128	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	4,095	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	7,371	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	11,466	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	12,874	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	8,225	36.00
37.00	Assistants (line 6 times column 3, line 11)	11,162	37.00
38.00	Subtotal (sum of lines 36 and 37)	19,387	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	3,724	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151322	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/24/2016 9:32 am

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		3,724	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	68.25	51.19	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	316,514	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	12,874	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	3,724	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	203	62.00
63.00	Total allowance (sum of lines 57-62)	333,315	63.00
64.00	Total cost of outside supplier services (from your records)	219,068	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	8,720	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,408	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	10,128	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,408	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	11,466	101.01
101.02	Line 34 = sum of lines 27 and 31	12,874	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	11,466	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	11,466	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/24/2016 9:32 am

Speech Pathology | Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	244	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	60	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	5.50	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	779.00	1,199.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	78.96	59.22	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	29.61	29.61	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	330	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	61,510	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	71,005	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	132,515	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	132,515	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	132,515	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	7,225	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	7,225	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,342	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	8,567	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	8,567	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	1,777	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	1,777	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	330	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	2,107	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/24/2016 9:32 am

Speech Pathology — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	59.22	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	132,515		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	8,567		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	2,107		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	9		61.00
62.00	Supplies (see instructions)	1,445		62.00
63.00	Total allowance (sum of lines 57-62)	144,643		63.00
64.00	Total cost of outside supplier services (from your records)	140,015		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	7,225		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,342		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	8,567		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,342		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	1,342		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/24/2016 9:32 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	876,762	876,762				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,682,958		1,682,958			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	201,352	5,600	10,749	217,701		4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	2,190,674	63,655	122,187	8,396	2,384,912	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	3,158,473	53,894	103,450	24,347	3,340,164	5.02
7.00	00700	OPERATION OF PLANT	1,398,758	145,768	279,802	5,060	1,829,388	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	85,592	4,836	9,283	14	99,725	8.00
9.00	00900	HOUSEKEEPING	484,098	8,160	15,663	3,441	511,362	9.00
10.00	01000	DIETARY	242,400	43,897	84,261	216	370,774	10.00
11.00	01100	CAFETERIA	312,759	0	0	416	313,175	11.00
13.00	01300	NURSING ADMINISTRATION	679,508	3,844	7,379	9,706	700,437	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	362,646	12,963	24,884	3,211	403,704	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,661,110	135,007	259,148	24,209	3,079,474	30.00
31.00	03100	INTENSIVE CARE UNIT	299,679	21,376	41,031	4,331	366,417	31.00
43.00	04300	NURSERY	55,182	4,649	8,924	918	69,673	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	919,389	82,950	159,224	6,921	1,168,484	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53,574	18,084	34,712	891	107,261	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,657,002	49,708	95,416	14,721	1,816,847	54.00
60.00	06000	LABORATORY	1,893,572	16,987	32,606	10,488	1,953,653	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	116,975	0	0	174	117,149	62.00
65.00	06500	RESPIRATORY THERAPY	961,499	27,650	53,075	8,312	1,050,536	65.00
66.00	06600	PHYSICAL THERAPY	472,644	22,798	43,761	402	539,605	66.00
67.00	06700	OCCUPATIONAL THERAPY	188,745	4,909	9,423	0	203,077	67.00
68.00	06800	SPEECH PATHOLOGY	122,181	2,820	5,414	0	130,415	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	320,386	683	1,310	718	323,097	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	111,063	0	0	0	111,063	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,368,553	10,964	21,046	1,335	2,401,898	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	1,441,440	0	0	13,062	1,454,502	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	281,419	0	0	2,092	283,511	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	51,928	0	0	351	52,279	88.02
90.00	09000	CLINIC	571,749	32,844	63,044	4,388	672,025	90.00
90.01	09001	PAIN MANAGEMENT	108,865	2,568	4,930	1,404	117,767	90.01
91.00	09100	EMERGENCY	1,787,371	44,791	85,977	13,938	1,932,077	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	810,737	40,394	77,537	8,616	937,284	95.00
101.00	10100	HOME HEALTH AGENCY	684,280	4,771	9,158	4,933	703,142	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)	29,615,323	866,570	1,663,394	177,011	29,544,877	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,274	17,801	0	27,075	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,168,107	0	0	40,407	4,208,514	192.00
192.01	19201	MARKETING	274,191	918	1,763	283	277,155	192.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	34,057,621	876,762	1,682,958	217,701	34,057,621	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/24/2016 9:32 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5A.01	5.02	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	2,384,912					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	251,511	3,591,675	3,591,675			5.02
7.00	00700	OPERATION OF PLANT	137,751	1,967,139	272,366	2,239,505		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,509	107,234	14,847	17,817	139,898	8.00
9.00	00900	HOUSEKEEPING	38,505	549,867	76,133	30,064	10,822	9.00
10.00	01000	DIETARY	27,919	398,693	55,202	161,731	0	10.00
11.00	01100	CAFETERIA	23,582	336,757	46,627	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	52,742	753,179	104,284	14,164	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,399	434,103	60,105	47,762	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	231,881	3,311,355	458,482	497,411	43,635	30.00
31.00	03100	INTENSIVE CARE UNIT	27,591	394,008	54,554	78,755	1,346	31.00
43.00	04300	NURSERY	5,246	74,919	10,373	17,128	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	87,986	1,256,470	173,968	305,616	12,042	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,077	115,338	15,969	66,627	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	136,807	1,953,654	270,499	183,142	16,366	54.00
60.00	06000	LABORATORY	147,108	2,100,761	290,867	62,584	230	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	8,821	125,970	17,442	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	79,104	1,129,640	156,408	101,872	805	65.00
66.00	06600	PHYSICAL THERAPY	40,632	580,237	80,338	83,995	4,784	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,291	218,368	30,235	18,087	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,820	140,235	19,417	10,391	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,329	347,426	48,104	2,515	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,363	119,426	16,535	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	180,861	2,582,759	357,604	40,395	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	109,523	1,564,025	216,552	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	21,348	304,859	42,210	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	3,937	56,216	7,784	0	0	88.02
90.00	09000	CLINIC	50,603	722,628	100,054	121,007	3,324	90.00
90.01	09001	PAIN MANAGEMENT	8,868	126,635	17,534	9,463	0	90.01
91.00	09100	EMERGENCY	145,483	2,077,560	287,655	165,025	46,544	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	70,577	1,007,861	139,546	148,825	0	95.00
101.00	10100	HOME HEALTH AGENCY	52,946	756,088	104,686	17,578	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)	2,045,120	29,205,085	3,546,380	2,201,954	139,898	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,039	29,114	4,031	34,167	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	316,884	4,525,398	0	0	0	192.00
192.01	19201	MARKETING	20,869	298,024	41,264	3,384	0	192.01
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)	2,384,912	34,057,621	3,591,675	2,239,505	139,898	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/24/2016 9:32 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	666,886					9.00
10.00	01000	DIETARY	49,213	664,839				10.00
11.00	01100	CAFETERIA	0	0	383,384			11.00
13.00	01300	NURSING ADMINISTRATION	4,310	0	24,341	900,278		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,533	0	15,406	0	571,909	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	151,356	629,270	98,781	436,127	72,674	30.00
31.00	03100	INTENSIVE CARE UNIT	23,964	35,569	13,434	59,311	0	31.00
43.00	04300	NURSERY	5,212	0	3,389	14,964	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	92,995	0	20,582	90,871	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,274	0	3,266	14,420	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,728	0	48,404	0	192,743	54.00
60.00	06000	LABORATORY	19,044	0	43,752	0	157,986	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	616	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	30,998	0	28,654	0	37,917	65.00
66.00	06600	PHYSICAL THERAPY	25,559	0	2,927	0	22,118	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,504	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,162	0	0	0	9,479	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	765	0	2,557	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	12,292	0	6,933	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0	0	0	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0	0	0	0	0	88.02
90.00	09000	CLINIC	36,821	0	17,686	78,084	28,437	90.00
90.01	09001	PAIN MANAGEMENT	2,879	0	5,885	0	0	90.01
91.00	09100	EMERGENCY	50,215	0	46,771	206,501	50,555	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	45,286	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	5,349	0	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)	655,459	664,839	383,384	900,278	571,909	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,397	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MARKETING	1,030	0	0	0	0	192.01
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)	666,886	664,839	383,384	900,278	571,909	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/24/2016 9:32 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	ADMINISTRATIVE AND GENERAL					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL					5.02
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,699,091	0	5,699,091		30.00
31.00	03100	INTENSIVE CARE UNIT	660,941	0	660,941		31.00
43.00	04300	NURSERY	125,985	0	125,985		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,952,544	0	1,952,544		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	235,894	0	235,894		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,720,536	0	2,720,536		54.00
60.00	06000	LABORATORY	2,675,224	0	2,675,224		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	144,028	0	144,028		62.00
65.00	06500	RESPIRATORY THERAPY	1,486,294	0	1,486,294		65.00
66.00	06600	PHYSICAL THERAPY	799,958	0	799,958		66.00
67.00	06700	OCCUPATIONAL THERAPY	272,194	0	272,194		67.00
68.00	06800	SPEECH PATHOLOGY	182,684	0	182,684		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	401,367	0	401,367		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	135,961	0	135,961		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,999,983	0	2,999,983		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	1,780,577	0	1,780,577		88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	347,069	0	347,069		88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	64,000	0	64,000		88.02
90.00	09000	CLINIC	1,108,041	0	1,108,041		90.00
90.01	09001	PAIN MANAGEMENT	162,396	0	162,396		90.01
91.00	09100	EMERGENCY	2,930,826	0	2,930,826		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,341,518	0	1,341,518		95.00
101.00	10100	HOME HEALTH AGENCY	883,701	0	883,701		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,110,812	0	29,110,812		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	77,709	0	77,709		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,525,398	0	4,525,398		192.00
192.01	19201	MARKETING	343,702	0	343,702		192.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	34,057,621	0	34,057,621		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/24/2016 9:32 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,600	10,749	16,349	16,349	4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	0	63,655	122,187	185,842	631	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	53,894	103,450	157,344	1,829	5.02
7.00	00700	OPERATION OF PLANT	0	145,768	279,802	425,570	380	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,836	9,283	14,119	1	8.00
9.00	00900	HOUSEKEEPING	0	8,160	15,663	23,823	258	9.00
10.00	01000	DIETARY	0	43,897	84,261	128,158	16	10.00
11.00	01100	CAFETERIA	0	0	0	0	31	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,844	7,379	11,223	729	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,963	24,884	37,847	241	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	135,007	259,148	394,155	1,818	30.00
31.00	03100	INTENSIVE CARE UNIT	0	21,376	41,031	62,407	325	31.00
43.00	04300	NURSERY	0	4,649	8,924	13,573	69	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	82,950	159,224	242,174	520	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	18,084	34,712	52,796	67	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,708	95,416	145,124	1,106	54.00
60.00	06000	LABORATORY	0	16,987	32,606	49,593	788	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	13	62.00
65.00	06500	RESPIRATORY THERAPY	0	27,650	53,075	80,725	624	65.00
66.00	06600	PHYSICAL THERAPY	0	22,798	43,761	66,559	30	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,909	9,423	14,332	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,820	5,414	8,234	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	683	1,310	1,993	54	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	10,964	21,046	32,010	100	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	0	0	0	0	981	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0	0	0	0	157	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0	0	0	0	26	88.02
90.00	09000	CLINIC	0	32,844	63,044	95,888	330	90.00
90.01	09001	PAIN MANAGEMENT	0	2,568	4,930	7,498	105	90.01
91.00	09100	EMERGENCY	0	44,791	85,977	130,768	1,047	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	40,394	77,537	117,931	647	95.00
101.00	10100	HOME HEALTH AGENCY	0	4,771	9,158	13,929	371	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	866,570	1,663,394	2,529,964	13,294	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,274	17,801	27,075	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	3,034	192.00
192.01	19201	MARKETING	0	918	1,763	2,681	21	192.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	876,762	1,682,958	2,559,720	16,349	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/24/2016 9:32 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	186,473					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	19,664	178,837				5.02
7.00	00700	OPERATION OF PLANT	10,770	13,561	450,281			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	587	739	3,582	19,028		8.00
9.00	00900	HOUSEKEEPING	3,010	3,791	6,045	1,472	38,399	9.00
10.00	01000	DIETARY	2,183	2,749	32,518	0	2,834	10.00
11.00	01100	CAFETERIA	1,844	2,322	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,123	5,192	2,848	0	248	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,377	2,993	9,603	0	837	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,129	22,832	100,011	5,935	8,713	30.00
31.00	03100	INTENSIVE CARE UNIT	2,157	2,716	15,835	183	1,380	31.00
43.00	04300	NURSERY	410	516	3,444	0	300	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,879	8,662	61,448	1,638	5,355	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	631	795	13,396	0	1,167	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,696	13,468	36,823	2,226	3,209	54.00
60.00	06000	LABORATORY	11,501	14,483	12,583	31	1,097	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	690	868	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	6,185	7,788	20,483	110	1,785	65.00
66.00	06600	PHYSICAL THERAPY	3,177	4,000	16,888	651	1,472	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,196	1,505	3,637	0	317	67.00
68.00	06800	SPEECH PATHOLOGY	768	967	2,089	0	182	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,902	2,395	506	0	44	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	654	823	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,140	17,806	8,122	0	708	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	8,563	10,782	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	1,669	2,102	0	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	308	388	0	0	0	88.02
90.00	09000	CLINIC	3,956	4,982	24,330	452	2,120	90.00
90.01	09001	PAIN MANAGEMENT	693	873	1,903	0	166	90.01
91.00	09100	EMERGENCY	11,374	14,323	33,180	6,330	2,891	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,518	6,948	29,923	0	2,608	95.00
101.00	10100	HOME HEALTH AGENCY	4,139	5,212	3,534	0	308	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)	159,893	176,581	442,731	19,028	37,741	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	159	201	6,870	0	599	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	24,789	0	0	0	0	192.00
192.01	19201	MARKETING	1,632	2,055	680	0	59	192.01
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)	186,473	178,837	450,281	19,028	38,399	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/24/2016 9:32 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	
			10.00	11.00	13.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	168,458					10.00
11.00	01100	CAFETERIA	0	4,197				11.00
13.00	01300	NURSING ADMINISTRATION	0	266	24,629			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	169	0	54,067		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	159,446	1,081	11,932	6,870	730,922	30.00
31.00	03100	INTENSIVE CARE UNIT	9,012	147	1,623	0	95,785	31.00
43.00	04300	NURSERY	0	37	409	0	18,758	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	225	2,486	0	329,387	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	36	394	0	69,282	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	530	0	18,222	231,404	54.00
60.00	06000	LABORATORY	0	479	0	14,936	105,491	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	7	0	0	1,578	62.00
65.00	06500	RESPIRATORY THERAPY	0	314	0	3,585	121,599	65.00
66.00	06600	PHYSICAL THERAPY	0	32	0	2,091	94,900	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	20,987	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	896	13,136	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	28	0	0	6,922	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,477	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	76	0	0	72,962	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	0	0	0	0	20,326	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0	0	0	0	3,928	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0	0	0	0	722	88.02
90.00	09000	CLINIC	0	194	2,136	2,688	137,076	90.00
90.01	09001	PAIN MANAGEMENT	0	64	0	0	11,302	90.01
91.00	09100	EMERGENCY	0	512	5,649	4,779	210,853	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	163,575	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	27,493	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)	168,458	4,197	24,629	54,067	2,489,865	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	34,904	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	27,823	192.00
192.01	19201	MARKETING	0	0	0	0	7,128	192.01
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)	168,458	4,197	24,629	54,067	2,559,720	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/24/2016 9:32 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
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540	ADMINISTRATIVE AND GENERAL				5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL				5.02
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	730,922		30.00
31.00	03100	INTENSIVE CARE UNIT	0	95,785		31.00
43.00	04300	NURSERY	0	18,758		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	329,387		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	69,282		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	231,404		54.00
60.00	06000	LABORATORY	0	105,491		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,578		62.00
65.00	06500	RESPIRATORY THERAPY	0	121,599		65.00
66.00	06600	PHYSICAL THERAPY	0	94,900		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	20,987		67.00
68.00	06800	SPEECH PATHOLOGY	0	13,136		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,922		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,477		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	72,962		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	0	20,326		88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0	3,928		88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0	722		88.02
90.00	09000	CLINIC	0	137,076		90.00
90.01	09001	PAIN MANAGEMENT	0	11,302		90.01
91.00	09100	EMERGENCY	0	210,853		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	163,575		95.00
101.00	10100	HOME HEALTH AGENCY	0	27,493		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,489,865		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34,904		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	27,823		192.00
192.01	19201	MARKETING	0	7,128		192.01
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	2,559,720		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/24/2016 9:32 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	107,875					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		107,875				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	689	689	12,997,133			4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	7,832	7,832	501,264	-2,384,912	31,672,709	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	6,631	6,631	1,453,559	0	3,340,164	5.02
7.00	00700	OPERATION OF PLANT	17,935	17,935	302,068	0	1,829,388	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	595	595	847	0	99,725	8.00
9.00	00900	HOUSEKEEPING	1,004	1,004	205,429	0	511,362	9.00
10.00	01000	DIETARY	5,401	5,401	12,919	0	370,774	10.00
11.00	01100	CAFETERIA	0	0	24,861	0	313,175	11.00
13.00	01300	NURSING ADMINISTRATION	473	473	579,492	0	700,437	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,595	1,595	191,679	0	403,704	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,611	16,611	1,445,336	0	3,079,474	30.00
31.00	03100	INTENSIVE CARE UNIT	2,630	2,630	258,549	0	366,417	31.00
43.00	04300	NURSERY	572	572	54,786	0	69,673	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,206	10,206	413,207	0	1,168,484	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,225	2,225	53,189	0	107,261	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,116	6,116	878,879	0	1,816,847	54.00
60.00	06000	LABORATORY	2,090	2,090	626,177	0	1,953,653	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	10,387	0	117,149	62.00
65.00	06500	RESPIRATORY THERAPY	3,402	3,402	496,250	0	1,050,536	65.00
66.00	06600	PHYSICAL THERAPY	2,805	2,805	23,979	0	539,605	66.00
67.00	06700	OCCUPATIONAL THERAPY	604	604	0	0	203,077	67.00
68.00	06800	SPEECH PATHOLOGY	347	347	0	0	130,415	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	84	84	42,862	0	323,097	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	111,063	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,349	1,349	79,689	0	2,401,898	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	0	0	779,835	0	1,454,502	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0	0	124,912	0	283,511	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0	0	20,940	0	52,279	88.02
90.00	09000	CLINIC	4,041	4,041	261,964	0	672,025	90.00
90.01	09001	PAIN MANAGEMENT	316	316	83,814	0	117,767	90.01
91.00	09100	EMERGENCY	5,511	5,511	832,124	0	1,932,077	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,970	4,970	514,380	0	937,284	95.00
101.00	10100	HOME HEALTH AGENCY	587	587	294,527	0	703,142	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)	106,621	106,621	10,567,904	-2,384,912	27,159,965	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,141	1,141	0	0	27,075	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,412,320	0	4,208,514	192.00
192.01	19201	MARKETING	113	113	16,909	0	277,155	192.01
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)	876,762	1,682,958	217,701		2,384,912	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.127574	15.601001	0.016750		0.075299	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			16,349		186,473	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001258		0.005887	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/24/2016 9:32 am

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST NO PBP)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.02	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	-3,591,675	25,940,548				5.02
7.00	00700	OPERATION OF PLANT	0	1,967,139	74,788			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	107,234	595	12,164		8.00
9.00	00900	HOUSEKEEPING	0	549,867	1,004	941	73,189	9.00
10.00	01000	DIETARY	0	398,693	5,401	0	5,401	10.00
11.00	01100	CAFETERIA	0	336,757	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	753,179	473	0	473	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	434,103	1,595	0	1,595	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,311,355	16,611	3,794	16,611	30.00
31.00	03100	INTENSIVE CARE UNIT	0	394,008	2,630	117	2,630	31.00
43.00	04300	NURSERY	0	74,919	572	0	572	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,256,470	10,206	1,047	10,206	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	115,338	2,225	0	2,225	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,953,654	6,116	1,423	6,116	54.00
60.00	06000	LABORATORY	0	2,100,761	2,090	20	2,090	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	125,970	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,129,640	3,402	70	3,402	65.00
66.00	06600	PHYSICAL THERAPY	0	580,237	2,805	416	2,805	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	218,368	604	0	604	67.00
68.00	06800	SPEECH PATHOLOGY	0	140,235	347	0	347	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	347,426	84	0	84	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	119,426	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,582,759	1,349	0	1,349	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	0	1,564,025	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0	304,859	0	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0	56,216	0	0	0	88.02
90.00	09000	CLINIC	0	722,628	4,041	289	4,041	90.00
90.01	09001	PAIN MANAGEMENT	0	126,635	316	0	316	90.01
91.00	09100	EMERGENCY	0	2,077,560	5,511	4,047	5,511	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,007,861	4,970	0	4,970	95.00
101.00	10100	HOME HEALTH AGENCY	0	756,088	587	0	587	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)	-3,591,675	25,613,410	73,534	12,164	71,935	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29,114	1,141	0	1,141	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-4,525,398	0	0	0	0	192.00
192.01	19201	MARKETING	0	298,024	113	0	113	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		3,591,675	2,239,505	139,898	666,886	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.138458	29.944710	11.500987	9.111834	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		178,837	450,281	19,028	38,399	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.006894	6.020765	1.564288	0.524655	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/24/2016 9:32 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			10.00	11.00	13.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	12,430					10.00
11.00	01100	CAFETERIA	0	12,443				11.00
13.00	01300	NURSING ADMINISTRATION	0	790	6,618			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	500	0	181		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,765	3,206	3,206	23		30.00
31.00	03100	INTENSIVE CARE UNIT	665	436	436	0		31.00
43.00	04300	NURSERY	0	110	110	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	668	668	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	106	106	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,571	0	61		54.00
60.00	06000	LABORATORY	0	1,420	0	50		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	20	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	930	0	12		65.00
66.00	06600	PHYSICAL THERAPY	0	95	0	7		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	83	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	225	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	0	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0	0	0	0		88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0	0	0	0		88.02
90.00	09000	CLINIC	0	574	574	9		90.00
90.01	09001	PAIN MANAGEMENT	0	191	0	0		90.01
91.00	09100	EMERGENCY	0	1,518	1,518	16		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,430	12,443	6,618	181		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	MARKETING	0	0	0	0		192.01
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)	664,839	383,384	900,278	571,909		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	53.486645	30.811219	136.034754	3,159.718232		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	168,458	4,197	24,629	54,067		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	13.552534	0.337298	3.721517	298.712707		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/24/2016 9:32 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	5,699,091		5,699,091	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	660,941		660,941	0	0	31.00
43.00	04300	NURSERY	125,985		125,985	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,952,544		1,952,544	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	235,894		235,894	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,720,536		2,720,536	0	0	54.00
60.00	06000	LABORATORY	2,675,224		2,675,224	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	144,028		144,028	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,486,294	0	1,486,294	0	0	65.00
66.00	06600	PHYSICAL THERAPY	799,958	0	799,958	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	272,194	0	272,194	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	182,684	0	182,684	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	401,367		401,367	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	135,961		135,961	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,999,983		2,999,983	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	1,780,577		1,780,577	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	347,069		347,069	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	64,000		64,000	0	0	88.02
90.00	09000	CLINIC	1,108,041		1,108,041	0	0	90.00
90.01	09001	PAIN MANAGEMENT	162,396		162,396	0	0	90.01
91.00	09100	EMERGENCY	2,930,826		2,930,826	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	683,067		683,067		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,341,518		1,341,518	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	883,701		883,701		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	29,793,879	0	29,793,879	0	0	200.00
201.00		Less Observation Beds	683,067		683,067		0	201.00
202.00		Total (see instructions)	29,110,812	0	29,110,812	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/24/2016 9:32 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	2,671,517		2,671,517			30.00
31.00	03100	INTENSIVE CARE UNIT	429,125		429,125			31.00
43.00	04300	NURSERY	136,398		136,398			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	614,453	5,101,077	5,715,530	0.341621	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	438,735	324,674	763,409	0.309001	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,368,237	15,218,016	16,586,253	0.164024	0.000000	54.00
60.00	06000	LABORATORY	1,362,040	8,299,264	9,661,304	0.276901	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	106,699	164,806	271,505	0.530480	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,233,658	2,035,136	3,268,794	0.454692	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	461,392	1,734,489	2,195,881	0.364299	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	351,914	633,650	985,564	0.276181	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	68,941	429,994	498,935	0.366148	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,537,694	2,371,572	3,909,266	0.102671	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	118,707	118,707	1.145349	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,999,086	8,596,295	12,595,381	0.238181	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	0	889,661	889,661			88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0	177,819	177,819			88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0	27,582	27,582			88.02
90.00	09000	CLINIC	5,350	546,911	552,261	2.006372	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	226,435	226,435	0.717186	0.000000	90.01
91.00	09100	EMERGENCY	219,099	6,391,223	6,610,322	0.443371	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	40,468	436,538	477,006	1.431988	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,614,276	2,614,276	0.513151	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,726,519	1,726,519			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	15,044,806	58,064,644	73,109,450			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,044,806	58,064,644	73,109,450			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/24/2016 9:32 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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
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 - TELL CITY			88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP			88.01
88.02	08803	RURAL HEALTH CLINIC - TROY			88.02
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	PAIN MANAGEMENT	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/24/2016 9:32 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,699,091		5,699,091	0	5,699,091	30.00
31.00	03100	INTENSIVE CARE UNIT	660,941		660,941	0	660,941	31.00
43.00	04300	NURSERY	125,985		125,985	0	125,985	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,952,544		1,952,544	0	1,952,544	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	235,894		235,894	0	235,894	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,720,536		2,720,536	0	2,720,536	54.00
60.00	06000	LABORATORY	2,675,224		2,675,224	0	2,675,224	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	144,028		144,028	0	144,028	62.00
65.00	06500	RESPIRATORY THERAPY	1,486,294	0	1,486,294	0	1,486,294	65.00
66.00	06600	PHYSICAL THERAPY	799,958	0	799,958	0	799,958	66.00
67.00	06700	OCCUPATIONAL THERAPY	272,194	0	272,194	0	272,194	67.00
68.00	06800	SPEECH PATHOLOGY	182,684	0	182,684	0	182,684	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	401,367		401,367	0	401,367	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	135,961		135,961	0	135,961	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,999,983		2,999,983	0	2,999,983	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	1,780,577		1,780,577	0	1,780,577	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	347,069		347,069	0	347,069	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	64,000		64,000	0	64,000	88.02
90.00	09000	CLINIC	1,108,041		1,108,041	0	1,108,041	90.00
90.01	09001	PAIN MANAGEMENT	162,396		162,396	0	162,396	90.01
91.00	09100	EMERGENCY	2,930,826		2,930,826	0	2,930,826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	683,067		683,067		683,067	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,341,518		1,341,518	0	1,341,518	95.00
101.00	10100	HOME HEALTH AGENCY	883,701		883,701		883,701	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	29,793,879	0	29,793,879	0	29,793,879	200.00
201.00		Less Observation Beds	683,067		683,067		683,067	201.00
202.00		Total (see instructions)	29,110,812	0	29,110,812	0	29,110,812	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I | Date/Time Prepared: 5/24/2016 9:32 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,671,517		2,671,517			30.00
31.00	03100	INTENSIVE CARE UNIT	429,125		429,125			31.00
43.00	04300	NURSERY	136,398		136,398			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	614,453	5,101,077	5,715,530	0.341621	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	438,735	324,674	763,409	0.309001	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,368,237	15,218,016	16,586,253	0.164024	0.000000	54.00
60.00	06000	LABORATORY	1,362,040	8,299,264	9,661,304	0.276901	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	106,699	164,806	271,505	0.530480	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,233,658	2,035,136	3,268,794	0.454692	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	461,392	1,734,489	2,195,881	0.364299	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	351,914	633,650	985,564	0.276181	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	68,941	429,994	498,935	0.366148	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,537,694	2,371,572	3,909,266	0.102671	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	118,707	118,707	1.145349	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,999,086	8,596,295	12,595,381	0.238181	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	0	889,661	889,661	2.001411	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0	177,819	177,819	1.951811	0.000000	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0	27,582	27,582	2.320354	0.000000	88.02
90.00	09000	CLINIC	5,350	546,911	552,261	2.006372	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	226,435	226,435	0.717186	0.000000	90.01
91.00	09100	EMERGENCY	219,099	6,391,223	6,610,322	0.443371	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	40,468	436,538	477,006	1.431988	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,614,276	2,614,276	0.513151	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,726,519	1,726,519			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	15,044,806	58,064,644	73,109,450			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,044,806	58,064,644	73,109,450			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/24/2016 9:32 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.341621		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.309001		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164024		54.00
60.00	06000	LABORATORY	0.276901		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.530480		62.00
65.00	06500	RESPIRATORY THERAPY	0.454692		65.00
66.00	06600	PHYSICAL THERAPY	0.364299		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.276181		67.00
68.00	06800	SPEECH PATHOLOGY	0.366148		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.102671		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.145349		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.238181		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	2.001411		88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	1.951811		88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	2.320354		88.02
90.00	09000	CLINIC	2.006372		90.00
90.01	09001	PAIN MANAGEMENT	0.717186		90.01
91.00	09100	EMERGENCY	0.443371		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.431988		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.513151		95.00
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

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

Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part II Date/Time Prepared: 5/24/2016 9:32 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,952,544	329,387	1,623,157	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	235,894	69,282	166,612	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,720,536	231,404	2,489,132	0	0	54.00
60.00	06000	LABORATORY	2,675,224	105,491	2,569,733	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	144,028	1,578	142,450	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,486,294	121,599	1,364,695	0	0	65.00
66.00	06600	PHYSICAL THERAPY	799,958	94,900	705,058	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	272,194	20,987	251,207	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	182,684	13,136	169,548	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	401,367	6,922	394,445	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	135,961	1,477	134,484	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,999,983	72,962	2,927,021	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	1,780,577	20,326	1,760,251	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	347,069	3,928	343,141	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	64,000	722	63,278	0	0	88.02
90.00	09000	CLINIC	1,108,041	137,076	970,965	0	0	90.00
90.01	09001	PAIN MANAGEMENT	162,396	11,302	151,094	0	0	90.01
91.00	09100	EMERGENCY	2,930,826	210,853	2,719,973	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	683,067	114,847	568,220	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,341,518	163,575	1,177,943	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	883,701	27,493	856,208	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
200.00		Subtotal (sum of lines 50 thru 199)	23,307,862	1,759,247	21,548,615	0	0	200.00
201.00		Less Observation Beds	683,067	114,847	568,220	0	0	201.00
202.00		Total (line 200 minus line 201)	22,624,795	1,644,400	20,980,395	0	0	202.00

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

Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part II | Date/Time Prepared: 5/24/2016 9:32 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,952,544	5,715,530	0.341621		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	235,894	763,409	0.309001		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,720,536	16,586,253	0.164024		54.00
60.00	06000	LABORATORY	2,675,224	9,661,304	0.276901		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	144,028	271,505	0.530480		62.00
65.00	06500	RESPIRATORY THERAPY	1,486,294	3,268,794	0.454692		65.00
66.00	06600	PHYSICAL THERAPY	799,958	2,195,881	0.364299		66.00
67.00	06700	OCCUPATIONAL THERAPY	272,194	985,564	0.276181		67.00
68.00	06800	SPEECH PATHOLOGY	182,684	498,935	0.366148		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	401,367	3,909,266	0.102671		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	135,961	118,707	1.145349		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,999,983	12,595,381	0.238181		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	1,780,577	889,661	2.001411		88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	347,069	177,819	1.951811		88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	64,000	27,582	2.320354		88.02
90.00	09000	CLINIC	1,108,041	552,261	2.006372		90.00
90.01	09001	PAIN MANAGEMENT	162,396	226,435	0.717186		90.01
91.00	09100	EMERGENCY	2,930,826	6,610,322	0.443371		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	683,067	477,006	1.431988		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,341,518	2,614,276	0.513151		95.00
101.00	10100	HOME HEALTH AGENCY	883,701	1,726,519	0.511840		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0.000000		116.00
200.00		Subtotal (sum of lines 50 thru 199)	23,307,862	69,872,410			200.00
201.00		Less Observation Beds	683,067	0			201.00
202.00		Total (line 200 minus line 201)	22,624,795	69,872,410			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/24/2016 9:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	329,387	5,715,530	0.057630	134,892	7,774	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	69,282	763,409	0.090753	4,334	393	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	231,404	16,586,253	0.013952	585,488	8,169	54.00
60.00	06000	LABORATORY	105,491	9,661,304	0.010919	794,640	8,677	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,578	271,505	0.005812	61,045	355	62.00
65.00	06500	RESPIRATORY THERAPY	121,599	3,268,794	0.037200	799,752	29,751	65.00
66.00	06600	PHYSICAL THERAPY	94,900	2,195,881	0.043217	153,109	6,617	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,987	985,564	0.021294	85,252	1,815	67.00
68.00	06800	SPEECH PATHOLOGY	13,136	498,935	0.026328	31,329	825	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,922	3,909,266	0.001771	687,309	1,217	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,477	118,707	0.012442	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,962	12,595,381	0.005793	2,125,831	12,315	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	20,326	889,661	0.022847	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	3,928	177,819	0.022090	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	722	27,582	0.026176	0	0	88.02
90.00	09000	CLINIC	137,076	552,261	0.248209	937	233	90.00
90.01	09001	PAIN MANAGEMENT	11,302	226,435	0.049913	0	0	90.01
91.00	09100	EMERGENCY	210,853	6,610,322	0.031898	9,198	293	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	114,847	477,006	0.240766	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,568,179	65,531,615		5,473,116	78,434	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/24/2016 9:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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 - TELL CITY	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0	0	0	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/24/2016 9:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,715,530	0.000000	0.000000	134,892	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	763,409	0.000000	0.000000	4,334	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,586,253	0.000000	0.000000	585,488	54.00
60.00	06000	LABORATORY	0	9,661,304	0.000000	0.000000	794,640	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	271,505	0.000000	0.000000	61,045	62.00
65.00	06500	RESPIRATORY THERAPY	0	3,268,794	0.000000	0.000000	799,752	65.00
66.00	06600	PHYSICAL THERAPY	0	2,195,881	0.000000	0.000000	153,109	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	985,564	0.000000	0.000000	85,252	67.00
68.00	06800	SPEECH PATHOLOGY	0	498,935	0.000000	0.000000	31,329	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,909,266	0.000000	0.000000	687,309	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	118,707	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,595,381	0.000000	0.000000	2,125,831	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	0	889,661	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0	177,819	0.000000	0.000000	0	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0	27,582	0.000000	0.000000	0	88.02
90.00	09000	CLINIC	0	552,261	0.000000	0.000000	937	90.00
90.01	09001	PAIN MANAGEMENT	0	226,435	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	6,610,322	0.000000	0.000000	9,198	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	477,006	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	65,531,615			5,473,116	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/24/2016 9:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
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 - TELL CITY	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0	0	0		88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0	0	0		88.02
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	PAIN MANAGEMENT	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/24/2016 9:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.341621	0	1,818,047	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.309001	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164024	0	5,115,356	0	0	54.00
60.00	06000	LABORATORY	0.276901	0	3,119,417	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.530480	0	158,338	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.454692	0	962,384	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.364299	0	872,867	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.276181	0	140,867	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.366148	0	26,148	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.102671	0	680,053	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.145349	0	113,402	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.238181	0	3,920,175	9,045	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0.000000				0	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0.000000				0	88.02
90.00	09000	CLINIC	2.006372	0	164,735	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.717186	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.443371	0	1,213,879	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.431988	0	283,844	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.513151		0			95.00
200.00		Subtotal (see instructions)		0	18,589,512	9,045	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	18,589,512	9,045	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/24/2016 9:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	621,083	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	839,041	0		54.00
60.00	06000	LABORATORY	863,770	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	83,995	0		62.00
65.00	06500	RESPIRATORY THERAPY	437,588	0		65.00
66.00	06600	PHYSICAL THERAPY	317,985	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	38,905	0		67.00
68.00	06800	SPEECH PATHOLOGY	9,574	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	69,822	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	129,885	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	933,711	2,154		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0	0		88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0	0		88.02
90.00	09000	CLINIC	330,520	0		90.00
90.01	09001	PAIN MANAGEMENT	0	0		90.01
91.00	09100	EMERGENCY	538,199	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	406,461	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,620,539	2,154		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,620,539	2,154		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151322 | Component CCN: 15Z322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/24/2016 9:32 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.341621	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.309001	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164024	0	0	0	0	54.00
60.00	06000	LABORATORY	0.276901	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.530480	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.454692	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.364299	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.276181	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.366148	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.102671	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.145349	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.238181	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0.000000				0	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0.000000				0	88.02
90.00	09000	CLINIC	2.006372	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.717186	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.443371	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.431988	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.513151		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151322 | Component CCN: 15Z322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/24/2016 9:32 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0	0		88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0	0		88.02
90.00	09000	CLINIC	0	0		90.00
90.01	09001	PAIN MANAGEMENT	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I | Date/Time Prepared: 5/24/2016 9:32 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	730,922	173,379	557,543	2,673	208.58	30.00
31.00	INTENSIVE CARE UNIT	95,785		95,785	208	460.50	31.00
43.00	NURSERY	18,758		18,758	179	104.79	43.00
200.00	Total (lines 30-199)	845,465		672,086	3,060		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	161	33,581				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
43.00	NURSERY	179	18,757				43.00
200.00	Total (lines 30-199)	340	52,338				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/24/2016 9:32 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	329,387	5,715,530	0.057630	130,020	7,493	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	69,282	763,409	0.090753	78,480	7,122	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	231,404	16,586,253	0.013952	108,864	1,519	54.00
60.00	06000	LABORATORY	105,491	9,661,304	0.010919	164,922	1,801	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,578	271,505	0.005812	8,078	47	62.00
65.00	06500	RESPIRATORY THERAPY	121,599	3,268,794	0.037200	142,291	5,293	65.00
66.00	06600	PHYSICAL THERAPY	94,900	2,195,881	0.043217	5,287	228	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,987	985,564	0.021294	832	18	67.00
68.00	06800	SPEECH PATHOLOGY	13,136	498,935	0.026328	705	19	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,922	3,909,266	0.001771	153,948	273	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,477	118,707	0.012442	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,962	12,595,381	0.005793	306,997	1,778	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	20,326	889,661	0.022847	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	3,928	177,819	0.022090	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	722	27,582	0.026176	0	0	88.02
90.00	09000	CLINIC	137,076	552,261	0.248209	410	102	90.00
90.01	09001	PAIN MANAGEMENT	11,302	226,435	0.049913	0	0	90.01
91.00	09100	EMERGENCY	210,853	6,610,322	0.031898	49,792	1,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	114,847	477,006	0.240766	5,076	1,222	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,568,179	65,531,615		1,155,702	28,503	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 5/24/2016 9:32 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,673	0.00	161	0		30.00
31.00	03100	INTENSIVE CARE UNIT	208	0.00	0	0		31.00
43.00	04300	NURSERY	179	0.00	179	0		43.00
200.00		Total (lines 30-199)	3,060		340	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/24/2016 9:32 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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 - TELL CITY	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0	0	0	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/24/2016 9:32 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,715,530	0.000000	0.000000	130,020	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	763,409	0.000000	0.000000	78,480	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,586,253	0.000000	0.000000	108,864	54.00
60.00	06000	LABORATORY	0	9,661,304	0.000000	0.000000	164,922	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	271,505	0.000000	0.000000	8,078	62.00
65.00	06500	RESPIRATORY THERAPY	0	3,268,794	0.000000	0.000000	142,291	65.00
66.00	06600	PHYSICAL THERAPY	0	2,195,881	0.000000	0.000000	5,287	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	985,564	0.000000	0.000000	832	67.00
68.00	06800	SPEECH PATHOLOGY	0	498,935	0.000000	0.000000	705	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,909,266	0.000000	0.000000	153,948	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	118,707	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,595,381	0.000000	0.000000	306,997	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	0	889,661	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0	177,819	0.000000	0.000000	0	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0	27,582	0.000000	0.000000	0	88.02
90.00	09000	CLINIC	0	552,261	0.000000	0.000000	410	90.00
90.01	09001	PAIN MANAGEMENT	0	226,435	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	6,610,322	0.000000	0.000000	49,792	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	477,006	0.000000	0.000000	5,076	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	65,531,615			1,155,702	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/24/2016 9:32 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
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 - TELL CITY	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0	0	0		88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0	0	0		88.02
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	PAIN MANAGEMENT	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/24/2016 9:32 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.341621	0	500,593	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.309001	0	49,420	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164024	0	2,053,950	0	0	54.00
60.00	06000	LABORATORY	0.276901	0	1,176,512	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.530480	0	5,151	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.454692	0	225,048	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.364299	0	202,510	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.276181	0	125,114	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.366148	0	76,361	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.102671	0	479,840	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.145349	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.238181	0	1,545,325	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	2.001411				0	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	1.951811				0	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	2.320354				0	88.02
90.00	09000	CLINIC	2.006372	0	60,793	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.717186	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.443371	0	1,588,068	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.431988	0	30,254	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.513151	0	231,066			95.00
200.00		Subtotal (see instructions)		0	8,350,005	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	8,350,005	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/24/2016 9:32 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	171,013	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,271	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	336,897	0		54.00
60.00	06000	LABORATORY	325,777	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,733	0		62.00
65.00	06500	RESPIRATORY THERAPY	102,328	0		65.00
66.00	06600	PHYSICAL THERAPY	73,774	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	34,554	0		67.00
68.00	06800	SPEECH PATHOLOGY	27,959	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,266	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	368,067	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0	0		88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0	0		88.02
90.00	09000	CLINIC	121,973	0		90.00
90.01	09001	PAIN MANAGEMENT	0	0		90.01
91.00	09100	EMERGENCY	704,103	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	43,323	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	118,572			95.00
200.00		Subtotal (see instructions)	2,495,610	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	2,495,610	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/24/2016 9:32 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,586	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,673	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)	2,253	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	824	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	89	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)	1,450	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)	824	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	132.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,699,091	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	11,748	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)	1,351,860	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,347,231	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,347,231	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)	1,626.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,358,208	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)	2,358,208	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/24/2016 9:32 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	660,941	208	3,177.60	89	282,806	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)	1,433,167	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,074,181	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)	1,340,112	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)	1,340,112	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)	420	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,626.35	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	683,067	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/24/2016 9:32 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	730,922	4,347,231	0.168135	683,067	114,847	90.00
91.00	Nursing School cost	0	4,347,231	0.000000	683,067	0	91.00
92.00	Allied health cost	0	4,347,231	0.000000	683,067	0	92.00
93.00	All other Medical Education	0	4,347,231	0.000000	683,067	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151322	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/24/2016 9:32 am
	Title XIX	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,586	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,673	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)	2,253	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	824	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	89	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)	161	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	89	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)	179	15.00
16.00	Nursery days (title V or XIX only)	179	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	132.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,699,091	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	11,748	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)	1,351,860	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,347,231	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,347,231	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)	1,626.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	261,842	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)	261,842	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/24/2016 9:32 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	125,985	179	703.83	179	125,986	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	660,941	208	3,177.60	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	322,684	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	710,512	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)	52,338	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	28,503	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	80,841	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	629,671	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)	11,748	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)	11,748	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)	420	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,626.35	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	683,067	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/24/2016 9:32 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	730,922	4,347,231	0.168135	683,067	114,847	90.00
91.00	Nursing School cost	0	4,347,231	0.000000	683,067	0	91.00
92.00	Allied health cost	0	4,347,231	0.000000	683,067	0	92.00
93.00	All other Medical Education	0	4,347,231	0.000000	683,067	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/24/2016 9:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,423,106		30.00
31.00	03100	INTENSIVE CARE UNIT		193,092		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.341621	134,892	46,082	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.309001	4,334	1,339	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164024	585,488	96,034	54.00
60.00	06000	LABORATORY	0.276901	794,640	220,037	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.530480	61,045	32,383	62.00
65.00	06500	RESPIRATORY THERAPY	0.454692	799,752	363,641	65.00
66.00	06600	PHYSICAL THERAPY	0.364299	153,109	55,777	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.276181	85,252	23,545	67.00
68.00	06800	SPEECH PATHOLOGY	0.366148	31,329	11,471	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.102671	687,309	70,567	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.145349	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.238181	2,125,831	506,333	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0.000000		0	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0.000000		0	88.02
90.00	09000	CLINIC	2.006372	937	1,880	90.00
90.01	09001	PAIN MANAGEMENT	0.717186	0	0	90.01
91.00	09100	EMERGENCY	0.443371	9,198	4,078	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.431988	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		5,473,116	1,433,167	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)		5,473,116		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151322 | Component CCN: 15Z322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/24/2016 9:32 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.341621	246	84	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.309001	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164024	26,592	4,362	54.00
60.00	06000	LABORATORY	0.276901	67,878	18,795	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.530480	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.454692	215,672	98,064	65.00
66.00	06600	PHYSICAL THERAPY	0.364299	253,755	92,443	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.276181	235,965	65,169	67.00
68.00	06800	SPEECH PATHOLOGY	0.366148	30,786	11,272	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.102671	193,068	19,822	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.145349	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.238181	378,175	90,074	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	0.000000		0	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	0.000000		0	88.02
90.00	09000	CLINIC	2.006372	52	104	90.00
90.01	09001	PAIN MANAGEMENT	0.717186	0	0	90.01
91.00	09100	EMERGENCY	0.443371	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.431988	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,402,189	400,189	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)		1,402,189		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/24/2016 9:32 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		220,560		30.00
31.00	03100	INTENSIVE CARE UNIT		26,290		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.341621	130,020	44,418	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.309001	78,480	24,250	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164024	108,864	17,856	54.00
60.00	06000	LABORATORY	0.276901	164,922	45,667	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.530480	8,078	4,285	62.00
65.00	06500	RESPIRATORY THERAPY	0.454692	142,291	64,699	65.00
66.00	06600	PHYSICAL THERAPY	0.364299	5,287	1,926	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.276181	832	230	67.00
68.00	06800	SPEECH PATHOLOGY	0.366148	705	258	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.102671	153,948	15,806	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.145349	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.238181	306,997	73,121	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - TELL CITY	2.001411	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - PERRY CO FP	1.951811	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC - TROY	2.320354	0	0	88.02
90.00	09000	CLINIC	2.006372	410	823	90.00
90.01	09001	PAIN MANAGEMENT	0.717186	0	0	90.01
91.00	09100	EMERGENCY	0.443371	49,792	22,076	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.431988	5,076	7,269	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,155,702	322,684	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)		1,155,702		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151322	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/24/2016 9:32 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,622,693	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,622,693	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,678,920	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)	58,135	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,077,018	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,543,767	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,543,767	30.00
31.00	Primary payer payments	820	31.00
32.00	Subtotal (line 30 minus line 31)	2,542,947	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)	458,721	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	298,169	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	318,926	36.00
37.00	Subtotal (see instructions)	2,841,116	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,841,116	40.00
40.01	Sequestration adjustment (see instructions)	56,822	40.01
41.00	Interim payments	2,554,144	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	230,150	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: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2016 9:32 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,190,811		2,253,044	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/07/2015	525,000	12/07/2015	301,100	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)		525,000		301,100	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)		3,715,811		2,554,144	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		230,150	6.01
6.02	SETTLEMENT TO PROGRAM		45,481		0	6.02
7.00	Total Medicare program liability (see instructions)		3,670,330		2,784,294	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151322 | Component CCN: 15Z322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2016 9:32 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,482,294		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/07/2015	242,900		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		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)		242,900		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,725,194		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		8,047		0	6.02
7.00	Total Medicare program liability (see instructions)		1,717,147		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 151322	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/24/2016 9:32 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	783	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,539	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	184	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,461	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	73,109,450	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	805,741	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	1	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1	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)	1	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151322 | Component CCN: 15Z322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-2 | Date/Time Prepared: 5/24/2016 9:32 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,353,513	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	404,191	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	824	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,757,704	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,757,704	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,757,704	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,513	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,752,191	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,752,191	0	19.00
19.01	Sequestration adjustment (see instructions)	35,044	0	19.01
20.00	Interim payments	1,725,194	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-8,047	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151322	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part V Date/Time Prepared: 5/24/2016 9:32 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,074,181	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)	4,074,181	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,114,923	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)	4,114,923	19.00
20.00	Deductibles (exclude professional component)	410,363	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,704,560	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,704,560	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	62,577	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	40,675	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	43,570	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,745,235	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)	3,745,235	30.00
30.01	Sequestration adjustment (see instructions)	74,905	30.01
31.00	Interim payments	3,715,811	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)	-45,481	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/24/2016 9:32 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,096,706	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	10,240,800	0	0	0	4.00
5.00	Other receivable	1,055,451	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,856,422	0	0	0	6.00
7.00	Inventory	1,026,740	0	0	0	7.00
8.00	Prepaid expenses	624,503	0	0	0	8.00
9.00	Other current assets	4,936,813	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)	15,124,591	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	43,193,514	0	0	0	15.00
16.00	Accumulated depreciation	-22,795,777	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	20,397,737	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	1,975,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,975,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	37,497,328	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	905,894	0	0	0	37.00
38.00	Salaries, wages, and fees payable	926,518	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	42,210	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	534,077	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,408,699	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,749,258	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	3,749,258	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	6,157,957	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	31,339,371				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)	31,339,371	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	37,497,328	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/24/2016 9:32 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		31,418,635		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-79,264				2.00
3.00	Total (sum of line 1 and line 2)		31,339,371		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		31,339,371		0		11.00
12.00		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)		31,339,371		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			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: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/24/2016 9:32 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,807,915		2,807,915	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)	2,807,915		2,807,915	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	429,125		429,125	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)	429,125		429,125	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,237,040		3,237,040	17.00
18.00	Ancillary services	11,810,766	52,625,787	64,436,553	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC - TELL CITY	0	889,661	889,661	20.00
20.01	RURAL HEALTH CLINIC - PERRY CO FP	0	177,819	177,819	20.01
20.02	RURAL HEALTH CLINIC - TROY	0	27,582	27,582	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,726,519	1,726,519	22.00
23.00	AMBULANCE SERVICES	0	2,614,276	2,614,276	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	PRO FEES	101,364	2,500,326	2,601,690	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	15,149,170	60,561,970	75,711,140	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		35,341,724		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	NON-OPERATING EXPENSES	5,266,598			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)		5,266,598		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		30,075,126		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151322	Period: From 01/01/2015 To 12/31/2015	Worksheet G-3 Date/Time Prepared: 5/24/2016 9:32 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	75,711,140	1.00
2.00	Less contractual allowances and discounts on patients' accounts	43,136,410	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,574,730	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	30,075,126	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,499,604	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-281,080	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	305,131	24.00
24.01	NON-OPERATING REVENUE	4,297,181	24.01
25.00	Total other income (sum of lines 6-24)	4,321,232	25.00
26.00	Total (line 5 plus line 25)	6,820,836	26.00
27.00	NON-OPERATING EXPENSE	6,900,100	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	6,900,100	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-79,264	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H

HHA CCN: 157177 | Date/Time Prepared: 5/24/2016 9:32 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	65,302	0	0	0	168,458	233,760	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	177,824	0	8,849	0	0	186,673	6.00
7.00	Physical Therapy	0	0	5,174	67,849	0	73,023	7.00
8.00	Occupational Therapy	0	0	2,330	30,557	0	32,887	8.00
9.00	Speech Pathology	0	0	1,489	19,530	0	21,019	9.00
10.00	Medical Social Services	660	0	31	0	0	691	10.00
11.00	Home Health Aide	50,741	0	3,603	0	0	54,344	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)	294,527	0	21,476	117,936	168,458	602,397	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	82,166	315,926	-283	315,643			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	186,673	0	186,673			6.00
7.00	Physical Therapy	0	73,023	0	73,023			7.00
8.00	Occupational Therapy	0	32,887	0	32,887			8.00
9.00	Speech Pathology	0	21,019	0	21,019			9.00
10.00	Medical Social Services	0	691	0	691			10.00
11.00	Home Health Aide	0	54,344	0	54,344			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)	82,166	684,563	-283	684,280			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: 151322 HHA CCN: 157177

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

Worksheet H-1 Part I Date/Time Prepared: 5/24/2016 9:32 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	315,643	0	0	0	0	315,643	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	186,673	0	0	0	0	186,673	6.00
7.00	Physical Therapy	73,023	0	0	0	0	73,023	7.00
8.00	Occupational Therapy	32,887	0	0	0	0	32,887	8.00
9.00	Speech Pathology	21,019	0	0	0	0	21,019	9.00
10.00	Medical Social Services	691	0	0	0	0	691	10.00
11.00	Home Health Aide	54,344	0	0	0	0	54,344	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)	684,280	0	0	0	0	684,280	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	315,643		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	159,838	346,511	6.00
7.00	Physical Therapy	62,525	135,548	7.00
8.00	Occupational Therapy	28,159	61,046	8.00
9.00	Speech Pathology	17,997	39,016	9.00
10.00	Medical Social Services	592	1,283	10.00
11.00	Home Health Aide	46,532	100,876	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)		684,280	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 151322 HHA CCN: 157177 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-1 Part II Date/Time Prepared: 5/24/2016 9:32 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-315,643	368,637	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	186,673	6.00
7.00	Physical Therapy	0	0	0	0	0	73,023	7.00
8.00	Occupational Therapy	0	0	0	0	0	32,887	8.00
9.00	Speech Pathology	0	0	0	0	0	21,019	9.00
10.00	Medical Social Services	0	0	0	0	0	691	10.00
11.00	Home Health Aide	0	0	0	0	0	54,344	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	-315,643	368,637	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		315,643	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.856243	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151322 HHA CCN: 157177 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part I Date/Time Prepared: 5/24/2016 9:32 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE AND GENERAL	
		0	1.00	2.00	4.00	4A	5.01	
1.00	Administrative and General	0	4,771	9,158	4,933	18,862	1,420	1.00
2.00	Skilled Nursing Care	346,511	0	0	0	346,511	26,091	2.00
3.00	Physical Therapy	135,548	0	0	0	135,548	10,207	3.00
4.00	Occupational Therapy	61,046	0	0	0	61,046	4,597	4.00
5.00	Speech Pathology	39,016	0	0	0	39,016	2,938	5.00
6.00	Medical Social Services	1,283	0	0	0	1,283	97	6.00
7.00	Home Health Aide	100,876	0	0	0	100,876	7,596	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)	684,280	4,771	9,158	4,933	703,142	52,946	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5A.01	5.02	7.00	8.00	9.00	10.00	
1.00	Administrative and General	20,282	2,808	17,578	0	5,349	0	1.00
2.00	Skilled Nursing Care	372,602	51,589	0	0	0	0	2.00
3.00	Physical Therapy	145,755	20,181	0	0	0	0	3.00
4.00	Occupational Therapy	65,643	9,089	0	0	0	0	4.00
5.00	Speech Pathology	41,954	5,809	0	0	0	0	5.00
6.00	Medical Social Services	1,380	191	0	0	0	0	6.00
7.00	Home Health Aide	108,472	15,019	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)	756,088	104,686	17,578	0	5,349	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: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part I | Date/Time Prepared: 5/24/2016 9:32 am

HHA CCN: 157177 | Home Health Agency I | PPS

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		11.00	13.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	0	46,017	0	46,017	1.00
2.00	Skilled Nursing Care	0	0	0	424,191	0	424,191	2.00
3.00	Physical Therapy	0	0	0	165,936	0	165,936	3.00
4.00	Occupational Therapy	0	0	0	74,732	0	74,732	4.00
5.00	Speech Pathology	0	0	0	47,763	0	47,763	5.00
6.00	Medical Social Services	0	0	0	1,571	0	1,571	6.00
7.00	Home Health Aide	0	0	0	123,491	0	123,491	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	883,701	0	883,701	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs	
		27.00	28.00	
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	23,302	447,493	2.00
3.00	Physical Therapy	9,116	175,052	3.00
4.00	Occupational Therapy	4,105	78,837	4.00
5.00	Speech Pathology	2,624	50,387	5.00
6.00	Medical Social Services	86	1,657	6.00
7.00	Home Health Aide	6,784	130,275	7.00
8.00	Supplies (see instructions)	0	0	8.00
9.00	Drugs	0	0	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	46,017	883,701	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.	0.054934		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: 151322 HHA CCN: 157177 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part II Date/Time Prepared: 5/24/2016 9:32 am

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	
		1.00	2.00	4.00	5A.01	5.01	5A.02	
1.00	Administrative and General	587	587	294,527	0	18,862	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	346,511	0	2.00
3.00	Physical Therapy	0	0	0	0	135,548	0	3.00
4.00	Occupational Therapy	0	0	0	0	61,046	0	4.00
5.00	Speech Pathology	0	0	0	0	39,016	0	5.00
6.00	Medical Social Services	0	0	0	0	1,283	0	6.00
7.00	Home Health Aide	0	0	0	0	100,876	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)	587	587	294,527		703,142		20.00
21.00	Total cost to be allocated	4,771	9,158	4,933		52,946		21.00
22.00	Unit cost multiplier	8.127768	15.601363	0.016749		0.075299		22.00

	Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST NO PBP)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		5.02	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	20,282	587	0	587	0	0	1.00
2.00	Skilled Nursing Care	372,602	0	0	0	0	0	2.00
3.00	Physical Therapy	145,755	0	0	0	0	0	3.00
4.00	Occupational Therapy	65,643	0	0	0	0	0	4.00
5.00	Speech Pathology	41,954	0	0	0	0	0	5.00
6.00	Medical Social Services	1,380	0	0	0	0	0	6.00
7.00	Home Health Aide	108,472	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)	756,088	587	0	587	0	0	20.00
21.00	Total cost to be allocated	104,686	17,578	0	5,349	0	0	21.00
22.00	Unit cost multiplier	0.138457	29.945486	0.000000	9.112436	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151322 | HHA CCN: 157177 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part II | Date/Time Prepared: 5/24/2016 9:32 am

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151322 | HHA CCN: 157177 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part I | Date/Time Prepared: 5/24/2016 9:32 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	447,493		447,493	1,852	241.63	1.00
2.00	Physical Therapy	3.00	175,052	0	175,052	1,007	173.84	2.00
3.00	Occupational Therapy	4.00	78,837	0	78,837	676	116.62	3.00
4.00	Speech Pathology	5.00	50,387	0	50,387	39	1,291.97	4.00
5.00	Medical Social Services	6.00	1,657		1,657	0	0.00	5.00
6.00	Home Health Aide	7.00	130,275		130,275	2,349	55.46	6.00
7.00	Total (sum of lines 1-6)		883,701	0	883,701	5,923		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		15999	0	1,100			8.00
9.00	Physical Therapy		15999	0	862			9.00
10.00	Occupational Therapy		15999	0	620			10.00
11.00	Speech Pathology		15999	0	14			11.00
12.00	Medical Social Services		15999	0	6			12.00
13.00	Home Health Aide		15999	0	116			13.00
14.00	Total (sum of lines 8-13)			0	2,718			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	5	5	19	0.263158	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,100		0	265,793		1.00
2.00	Physical Therapy	0	862		0	149,850		2.00
3.00	Occupational Therapy	0	620		0	72,304		3.00
4.00	Speech Pathology	0	14		0	18,088		4.00
5.00	Medical Social Services	0	6		0	0		5.00
6.00	Home Health Aide	0	116		0	6,433		6.00
7.00	Total (sum of lines 1-6)	0	2,718		0	512,468		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part I | Date/Time Prepared: 5/24/2016 9:32 am

HHA CCN: 157177 | Title XVIII | Home Health Agency I | PPS

	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		902	0		237	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	265,793	1.00
2.00	Physical Therapy	149,850	2.00
3.00	Occupational Therapy	72,304	3.00
4.00	Speech Pathology	18,088	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	6,433	6.00
7.00	Total (sum of lines 1-6)	512,468	7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part II | Date/Time Prepared: 5/24/2016 9:32 am

HHA CCN: 157177 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.364299	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.276181	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.366148	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.102671	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.238181	19	5	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-4 Part I-II

HHA CCN: 157177 | Date/Time Prepared: 5/24/2016 9:32 am

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	237	0	1.00
2.00	Total charges	0	759	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	759	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	522	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	237	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	421,314	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	7,883	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	7,022	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	1,152	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	1,053	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	438,661	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	438,661	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	438,661	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	438,661	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	438,661	31.00
31.01	Sequestration adjustment (see instructions)	0	8,769	31.01
32.00	Interim payments (see instructions)	0	430,539	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	-647	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: 151322 | HHA CCN: 157177 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-5 | Date/Time Prepared: 5/24/2016 9:32 am

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		430,539	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		430,539	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		647	6.02
7.00	Total Medicare program liability (see instructions)		0		429,892	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

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

Provider CCN: 151322 | Component CCN: 158516 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/24/2016 9:32 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	265,811	0	265,811	0	265,811	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	35,705	0	35,705	0	35,705	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	301,516	0	301,516	0	301,516	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)	301,516	0	301,516	0	301,516	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	0	0	0	0	29.00
30.00	Administrative Costs	478,336	449,376	927,712	212,212	1,139,924	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	478,336	449,376	927,712	212,212	1,139,924	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	779,852	449,376	1,229,228	212,212	1,441,440	32.00

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

Provider CCN: 151322 | Component CCN: 158516 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/24/2016 9:32 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	265,811		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	35,705		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	301,516		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	301,516		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	0		29.00
30.00	Administrative Costs	0	1,139,924		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	1,139,924		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,441,440		32.00

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

Provider CCN: 151322 | Component CCN: 158517 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/24/2016 9:32 am

Rural Health Clinic (RHC) II | 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	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	57,517	0	57,517	0	57,517	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	57,517	0	57,517	0	57,517	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)	57,517	0	57,517	0	57,517	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	0	0	0	0	29.00
30.00	Administrative Costs	67,395	115,046	182,441	41,461	223,902	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	67,395	115,046	182,441	41,461	223,902	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	124,912	115,046	239,958	41,461	281,419	32.00

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

Provider CCN: 151322 | Component CCN: 158517 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/24/2016 9:32 am

Rural Health Clinic (RHC) II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	57,517		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	57,517		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	57,517		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	0		29.00
30.00	Administrative Costs	0	223,902		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	223,902		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	281,419		32.00

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

Provider CCN: 151322 | Component CCN: 158518 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/24/2016 9:32 am

Rural Health Clinic (RHC) III | 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	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	13,447	0	13,447	0	13,447	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	13,447	0	13,447	0	13,447	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)	13,447	0	13,447	0	13,447	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	0	0	0	0	29.00
30.00	Administrative Costs	7,493	15,135	22,628	15,853	38,481	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	7,493	15,135	22,628	15,853	38,481	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	20,940	15,135	36,075	15,853	51,928	32.00

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

Provider CCN: 151322 | Component CCN: 158518 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/24/2016 9:32 am

Rural Health Clinic (RHC) III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	13,447		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	13,447		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	13,447		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	0		29.00
30.00	Administrative Costs	0	38,481		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	38,481		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	51,928		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-2

Component CCN: 158516 | Date/Time Prepared: 5/24/2016 9:32 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	1.05	3,856	4,200	4,410		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.91	1,373	2,100	1,911		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.96	5,229		6,321	6,321	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)	1.96	5,229			6,321	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)					301,516	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)					301,516	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)					1,139,924	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					339,137	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,479,061	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					1,479,061	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					1,479,061	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,780,577	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-2

Component CCN: 158517 | Date/Time Prepared: 5/24/2016 9:32 am

Rural Health Clinic (RHC) II | 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	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.53	1,148	2,100	1,113		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.53	1,148		1,113	1,148	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)	0.53	1,148			1,148	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)					57,517	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)					57,517	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)					223,902	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					65,650	15.00
16.00	Total overhead (sum of lines 14 and 15)					289,552	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					289,552	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					289,552	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					347,069	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-2

Component CCN: 158518 | Date/Time Prepared: 5/24/2016 9:32 am

Rural Health Clinic (RHC) III | 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	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.08	169	2,100	168		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.08	169		168	169	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)	0.08	169			169	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)					13,447	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)					13,447	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)					38,481	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					12,072	15.00
16.00	Total overhead (sum of lines 14 and 15)					50,553	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					50,553	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					50,553	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					64,000	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 151322 Component CCN: 158516	Period: From 01/01/2015 To 12/31/2015	Worksheet M-3 Date/Time Prepared: 5/24/2016 9:32 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)		1,780,577	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,780,577	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		6,321	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)		6,321	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		281.69	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)	0.00	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	281.69	281.69	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,664	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	468,732	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) *		468,732	16.00
16.01	Total program charges (see instructions)(from contractor's records)		223,554	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,740	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		7,842	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.)		363,365	16.04
16.05	Total program cost (see instructions)		371,207	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,684	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		42,626	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		371,207	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		371,207	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)		371,207	26.00
26.01	Sequestration adjustment (see instructions)		7,424	26.01
27.00	Interim payments		287,523	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)		76,260	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 151322 Component CCN: 158517	Period: From 01/01/2015 To 12/31/2015	Worksheet M-3 Date/Time Prepared: 5/24/2016 9:32 am
	Title XVIII	Rural Health Clinic (RHC) II	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)		347,069	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		347,069	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,148	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)		1,148	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		302.32	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)	0.00	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	302.32	302.32	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	63	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	19,046	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) *		19,046	16.00
16.01	Total program charges (see instructions)(from contractor's records)		8,215	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		326	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		756	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.)		14,511	16.04
16.05	Total program cost (see instructions)		15,267	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		151	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		1,548	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		15,267	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		15,267	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)		15,267	26.00
26.01	Sequestration adjustment (see instructions)		305	26.01
27.00	Interim payments		8,509	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)		6,453	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 151322 Component CCN: 158518	Period: From 01/01/2015 To 12/31/2015	Worksheet M-3 Date/Time Prepared: 5/24/2016 9:32 am
	Title XVIII	Rural Health Clinic (RHC) III	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)	64,000	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)	0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	64,000	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	169	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)	169	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	378.70	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)	0.00	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	378.70	378.70	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	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) *		0	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	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.)		0	16.04
16.05	Total program cost (see instructions)		0	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		0	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		0	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)		0	26.00
26.01	Sequestration adjustment (see instructions)		0	26.01
27.00	Interim payments		0	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)		0	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 151322 | Component CCN: 158516 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-5 | Date/Time Prepared: 5/24/2016 9:32 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		287,523	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)		287,523	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		76,260	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		363,783	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 151322 | Component CCN: 158517 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-5 | Date/Time Prepared: 5/24/2016 9:32 am

Rural Health Clinic (RHC) II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		8,509	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)		8,509	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		6,453	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		14,962	7.00

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