

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 6/19/2017 1:31 pm
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PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for Full or "L" for Low.

Date: 6/19/2017 Time: 1:31 pm

Contractor use only
 5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended

6. Date Received:
7. Contractor No.
8. Initial Report for this Provider CCN
9. Final Report for this Provider CCN

10. NPR Date:
11. Contractor's Vendor Code: 4
12. 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 PULASKI MEMORIAL HOSPITAL (15-1305) for the cost reporting period beginning 10/01/2014 and ending 09/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	303,335	-64,316	0	72,010	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	191,789	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00 RURAL HEALTH CLINIC I	0		484,935		0	10.00
200.00 Total	0	495,124	420,620	0	72,010	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1305		Period: From 10/01/2014 To 09/30/2015		Worksheet S-2 Part I Date/Time Prepared: 6/19/2017 1:30 pm						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 616 EAST 13TH			PO Box:						1.00		
2.00	City: WINAMAC			State: IN		Zip Code: 46996-		County: PULASKI		2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
		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	PULASKI MEMORIAL HOSPITAL	151305	99915	1	10/01/2000	N	O	O	3.00		
4.00	Subprovider - IPF									4.00		
5.00	Subprovider - IRF									5.00		
6.00	Subprovider - (Other)									6.00		
7.00	Swing Beds - SNF	PULASKI MEMORIAL HOSPITAL	15Z305	99915		10/01/2000	N	O	P	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	PULASKI MEMORIAL HOSPITAL	157078	99915		10/14/1982	N	P	N	12.00		
13.00	Separately Certified ASC									13.00		
14.00	Hospital-Based Hospice	PULASKI MEMORIAL HOSPICE	151550	99915		09/01/1997				14.00		
15.00	Hospital-Based Health Clinic - RHC	PULASKI MEMORIAL RHC	158512	99915		08/21/2014	N	O	N	15.00		
16.00	Hospital-Based Health Clinic - FQHC									16.00		
17.00	Hospital-Based (CMHC) I									17.00		
18.00	Renal Dialysis									18.00		
19.00	Other									19.00		
						From:		To:				
						1.00		2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2014		09/30/2015		20.00		
21.00	Type of Control (see instructions)					2				21.00		
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N		N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N		N		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N		N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N		N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							2		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	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							N		37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.									38.00	
						Y/N		Y/N			
						1.00		2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)							N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)							N	N	40.00	
						V	XVIII	XIX			
						1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital											
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)							N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.							N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.							N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.							N	N	N	48.00
Teaching Hospitals											
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.							N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.										57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.										58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.							N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)							N			60.00
		Y/N	IME	Direct GME	IME	Direct GME					
		1.00	2.00	3.00	4.00	5.00					
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)					0.00	0.00		61.00		
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)	0.00		0.00					61.01		

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	Y/N	IME	Direct GME	IME	Direct GME					
	1.00	2.00	3.00	4.00	5.00					
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)							61.02		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)							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).							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)							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)							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					
64.00	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. 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
70.00	Inpatient Psychiatric Facility PPS 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

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			1.00	2.00	3.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N	87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a critical access hospital (CAH)?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	Y	N
			1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N	110.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.		N	0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	75,769	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N	118.02	
119.00	DO NOT USE THIS LINE			119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N		122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:	Contractor's Number:		141.00
142.00	Street:	PO Box:			142.00
143.00	City:	State:	Zip Code:		143.00
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y	144.00
		1.00	2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.		N	N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
				1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N	149.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1305		Period: From 10/01/2014 To 09/30/2015		Worksheet S-2 Part I Date/Time Prepared: 6/19/2017 1:30 pm		
		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	N	161.00		
						1.00		
Multi campus								
165.00	Is this hospital part of a Multi campus 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)						168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00	169.00	
				Beginning	Ending			
				1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			10/01/2014	09/30/2015	170.00		
				1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)			N		0	171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1305		Period: From 10/01/2014 To 09/30/2015		Worksheet S-2 Part II Date/Time Prepared: 6/19/2017 1:30 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
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				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	01/07/2016	Y	01/07/2016		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part II Date/Time Prepared: 6/19/2017 1:30 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved 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.				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.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL		ALESSANDRINI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.713.7959		MALESSANDRINI@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part II Date/Time Prepared: 6/19/2017 1:30 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR 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: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
6/19/2017 1:30 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					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	25	9,125	45,744.00	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)		25	9,125	45,744.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	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	45,744.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
6/19/2017 1:30 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,058	77	1,885			1.00
2.00 HMO and other (see instructions)	74	323				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	677	0	677			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	175			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,735	77	2,737			7.00
8.00 INTENSIVE CARE UNIT	0	0	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		0	198			13.00
14.00 Total (see instructions)	1,735	77	2,935	0.00	175.44	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	2,809	1,537	4,359	0.00	8.64	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	0.88	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	3,625	365	18,849	0.00	36.88	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	221.84	27.00
28.00 Observation Bed Days		0	238			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	16			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
6/19/2017 1:30 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	304	28	590	1.00
2.00 HMO and other (see instructions)				16	132		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	304	28		590	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY	0.00						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE	0.00						24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC	0.00						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOME HEALTH AGENCY STATISTICAL DATA	Provider CCN: 15-1305 Component CCN: 15-7078	Period: From 10/01/2014 To 09/30/2015	Worksheet S-4 Date/Time Prepared: 6/19/2017 1:30 pm
		Home Health Agency I	PPS

		1.00					
0.00	County	PULASKI					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	132.00	0.00	0.00	0.00	2.00
		Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week			Staff	Contract	Total
		0			1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.42	0.00	0.42	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			3.43	0.00	3.43	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.64	0.00	0.64	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.16	0.00	0.16	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.06	0.00	0.06	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			2.18	0.00	2.18	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	HOMEMAKER			0.44	0.00	0.44	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99915			20.00
20.01				50031			20.01
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,104	0	53	21	1,178	21.00
22.00	Skilled Nursing Visit Charges	229,016	0	11,016	4,373	244,405	22.00
23.00	Physical Therapy Visits	576	0	16	2	594	23.00
24.00	Physical Therapy Visit Charges	130,498	0	3,635	454	134,587	24.00
25.00	Occupational Therapy Visits	125	0	0	1	126	25.00
26.00	Occupational Therapy Visit Charges	28,330	0	0	227	28,557	26.00
27.00	Speech Pathology Visits	46	0	0	0	46	27.00
28.00	Speech Pathology Visit Charges	10,449	0	0	0	10,449	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	854	0	4	7	865	31.00
32.00	Home Health Aide Visit Charges	81,868	0	375	673	82,916	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,705	0	73	31	2,809	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)	480,161	0	15,026	5,727	500,914	35.00
36.00	Total Number of Episodes (standard/non outlier)	159		28	3	190	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	37,176	0	2,426	462	40,064	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-1305 Component CCN: 15-8512		Period: From 10/01/2014 To 09/30/2015		Worksheet S-8 Date/Time Prepared: 6/19/2017 1:30 pm	
		RHC I		Cost			
				1.00			
1.00	Clinic Address and Identification Street	540 HOSPITAL DRIVE				1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00	City, State, ZIP Code, County	WINIMAC		IN		46996	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0		3.00	
		Grant Award		Date			
		1.00		2.00			
4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
				1.00		2.00	
10.00	Does this facility operate as other than a hospital-based 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	
11.00	Facility hours of operations (1) Clinic	08:00		17:00		08:00	
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0		13.00	
		Provider name		CCN number			
		1.00		2.00			
14.00	RHC/FQHC name, CCN number					14.00	
		Y/N		V		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	PULASKI				2.00	
		Tuesday		Wednesday		Thursday	
		to		from to		from to	
		6.00		7.00 8.00		9.00 10.00	
11.00	Facility hours of operations (1) Clinic	18:30		08:00		17:00	
		08:00		17:00		08:00	
		18:30				11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1305
Component CCN: 15-8512

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-8
Date/Time Prepared:
6/19/2017 1:30 pm

		RHC I		Cost		
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
11.00	Facility hours of operations (1) Clinic	08:00	16:30			11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA		Provider CCN: 15-1305 Hospice CCN: 15-1550	Period: From 10/01/2014 To 09/30/2015	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 6/19/2017 1:30 pm
		Hospice I		

	Unduplicated Days	Hospice I					Total (sum of cols. 1, 2 & 5)	
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other		
		1.00	2.00	3.00	4.00	5.00		
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
1.00	Hospice Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Hospice Routine Home Care	102	8	27	8	19	129	2.00
3.00	Hospice Inpatient Respite Care	0	0	0	0	0	0	3.00
4.00	Hospice General Inpatient Care	0	0	0	0	0	0	4.00
5.00	Total Hospice Days	102	8	27	8	19	129	5.00
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
6.00	Number of patients receiving hospice care	0	0	0	0	0	0	6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5 / line 6)	0.00	0.00	0.00	0.00	0.00	0.00	8.00
9.00	Unduplicated census count	5	8	7	8	9	22	9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

	Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
				1.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care				10.00
11.00	Hospice Routine Home Care				11.00
12.00	Hospice Inpatient Respite Care				12.00
13.00	Hospice General Inpatient Care				13.00
14.00	Total Hospice Days				14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care				15.00
16.00	Hospice General Inpatient Care				16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet S-10 Date/Time Prepared: 6/19/2017 1:30 pm
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			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)		0.461105	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,151,484	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		589,576	5.00
6.00	Medicaid charges		5,124,098	6.00
7.00	Medicaid cost (line 1 times line 6)		2,362,747	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)		621,687	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		621,687	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
20.00	Charity care charges for the entire facility (see instructions)	396,501	0	396,501
21.00	Cost of patients approved for charity care (line 1 times line 20)	182,829	0	182,829
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	182,829	0	182,829
				1.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,984,650	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		302,540	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		1,682,110	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		775,629	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		958,458	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,580,145	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 15-1305		Period: From 10/01/2014 To 09/30/2015		Worksheet A	
Date/Time Prepared: 6/19/2017 1:30 pm								
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		1,316,972	1,316,972	20,640	1,337,612	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,739,144	4,739,144	0	4,739,144	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,778,440	1,605,145	3,383,585	85,892	3,469,477	5.00
7.00	00700	OPERATION OF PLANT	240,208	483,218	723,426	1,314	724,740	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,492	41,492	58,984	0	58,984	8.00
9.00	00900	HOUSEKEEPING	139,125	69,377	208,502	0	208,502	9.00
10.00	01000	DIETARY	162,870	183,911	346,781	0	346,781	10.00
13.00	01300	NURSING ADMINISTRATION	368,481	24,833	393,314	0	393,314	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	43,732	25,649	69,381	0	69,381	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	243,662	58,495	302,157	0	302,157	16.00
17.00	01700	SOCIAL SERVICE	49,607	0	49,607	0	49,607	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,536,789	85,608	1,622,397	269,784	1,892,181	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	82,453	3,044	85,497	0	85,497	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	506,801	112,337	619,138	285,999	905,137	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	84,119	3,160	87,279	0	87,279	52.00
53.00	05300	ANESTHESIOLOGY	0	633,121	633,121	0	633,121	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	665,745	739,658	1,405,403	0	1,405,403	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	535,427	596,200	1,131,627	0	1,131,627	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	81,975	81,975	0	81,975	63.00
65.00	06500	RESPIRATORY THERAPY	234,722	21,906	256,628	0	256,628	65.00
66.00	06600	PHYSICAL THERAPY	485,931	11,909	497,840	0	497,840	66.00
67.00	06700	OCCUPATIONAL THERAPY	73,675	502	74,177	0	74,177	67.00
68.00	06800	SPEECH PATHOLOGY	106,849	7,767	114,616	0	114,616	68.00
69.00	06900	ELECTROCARDIOLOGY	27,073	8,387	35,460	0	35,460	69.00
69.01	06901	CARDIAC REHABILITATION	57,577	6,248	63,825	0	63,825	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	713,908	713,908	-314,756	399,152	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	314,756	314,756	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,792,569	1,792,569	0	1,792,569	73.00
76.00	03020	ONCOLOGY	86,840	38,844	125,684	0	125,684	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,419,472	297,712	3,717,184	-382,715	3,334,469	88.00
90.00	09000	CLINIC	77,104	229,768	306,872	0	306,872	90.00
91.00	09100	EMERGENCY	849,902	875,523	1,725,425	0	1,725,425	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	473,693	100,370	574,063	-52,571	521,492	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	39,713	2,840	42,553	0	42,553	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,387,502	14,911,592	27,299,094	228,343	27,527,437	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	HOMECARE	58,702	14,955	73,657	0	73,657	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,153,794	728,640	1,882,434	-174,382	1,708,052	192.00
194.00	07950	MARKETING	90,813	268,925	359,738	-53,961	305,777	194.00
200.00		TOTAL (SUM OF LINES 118-199)	13,690,811	15,924,112	29,614,923	0	29,614,923	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet A
Date/Time Prepared:
6/19/2017 1:30 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-11,867	1,325,745	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	4,739,144	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-233,209	3,236,268	5.00
7.00	00700 OPERATION OF PLANT	-278	724,462	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	58,984	8.00
9.00	00900 HOUSEKEEPING	0	208,502	9.00
10.00	01000 DIETARY	-65,635	281,146	10.00
13.00	01300 NURSING ADMINISTRATION	0	393,314	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-23,139	46,242	14.00
15.00	01500 PHARMACY	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-6,086	296,071	16.00
17.00	01700 SOCIAL SERVICE	0	49,607	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-269,784	1,622,397	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	31.00
43.00	04300 NURSERY	0	85,497	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-285,999	619,138	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	87,279	52.00
53.00	05300 ANESTHESIOLOGY	-614,256	18,865	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,405,403	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	1,131,627	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	81,975	63.00
65.00	06500 RESPIRATORY THERAPY	0	256,628	65.00
66.00	06600 PHYSICAL THERAPY	0	497,840	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	74,177	67.00
68.00	06800 SPEECH PATHOLOGY	0	114,616	68.00
69.00	06900 ELECTROCARDIOLOGY	-6,164	29,296	69.00
69.01	06901 CARDIAC REHABILITATION	0	63,825	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	399,152	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	314,756	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-119,375	1,673,194	73.00
76.00	03020 ONCOLOGY	0	125,684	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	3,334,469	88.00
90.00	09000 CLINIC	0	306,872	90.00
91.00	09100 EMERGENCY	0	1,725,425	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY	0	521,492	101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600 HOSPICE	0	42,553	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,635,792	25,891,645	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001 HOMECARE	0	73,657	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	1,708,052	192.00
194.00	07950 MARKETING	0	305,777	194.00
200.00	TOTAL (SUM OF LINES 118-199)	-1,635,792	27,979,131	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	20,640	1.00
	0		0	20,640	
B - MARKETING RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	13,622	40,339	1.00
	0		13,622	40,339	
C - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	314,756	1.00
	0		0	314,756	
D - PHYSICIAN SALARIES					
1.00	ADULTS & PEDIATRICS	30.00	78,552	0	1.00
2.00	OPERATING ROOM	50.00	285,999	0	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	18,164	0	3.00
	TOTALS		382,715	0	
E - TELEPHONE RECLASS					
1.00	OPERATION OF PLANT	7.00	0	1,314	1.00
	TOTALS		0	1,314	
F - HOME HEALTH BILLER RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	52,571	0	1.00
	TOTALS		52,571	0	
G - HOSPITALIST RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	191,107	125	1.00
	TOTALS		191,107	125	
500.00	Grand Total: Increases		640,015	377,174	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,640	12		1.00
	O		0	20,640			
	B - MARKETING RECLASS						
1.00	MARKETING	194.00	13,622	40,339	0		1.00
	O		13,622	40,339			
	C - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	314,756	0		1.00
	O		0	314,756			
	D - PHYSICIAN SALARIES						
1.00	RURAL HEALTH CLINIC	88.00	382,715	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		382,715	0			
	E - TELEPHONE RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,314	0		1.00
	TOTALS		0	1,314			
	F - HOME HEALTH BILLER RECLASS						
1.00	HOME HEALTH AGENCY	101.00	52,571	0	0		1.00
	TOTALS		52,571	0			
	G - HOSPITALIST RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	191,107	125	0		1.00
	TOTALS		191,107	125			
500.00	Grand Total: Decreases		640,015	377,174			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-7
Part I
Date/Time Prepared:
6/19/2017 1:30 pm

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
	1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	195,525	0	0	0	1.00	
2.00	Land Improvements	432,594	0	0	0	2.00	
3.00	Buildings and Fixtures	10,424,101	0	0	0	3.00	
4.00	Building Improvements	160,930	21,279	0	21,279	4.00	
5.00	Fixed Equipment	5,469,342	153,376	0	153,376	5.00	
6.00	Movable Equipment	7,976,903	131,035	0	131,035	6.00	
7.00	HIT designated Assets	292,850	316,678	0	316,678	132,836	7.00
8.00	Subtotal (sum of lines 1-7)	24,952,245	622,368	0	622,368	132,836	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24,952,245	622,368	0	622,368	132,836	10.00
	Ending Balance		Fully Depreciated Assets				
	6.00		7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	195,525	0			1.00	
2.00	Land Improvements	432,594	0			2.00	
3.00	Buildings and Fixtures	10,424,101	0			3.00	
4.00	Building Improvements	182,209	0			4.00	
5.00	Fixed Equipment	5,622,718	0			5.00	
6.00	Movable Equipment	8,107,938	0			6.00	
7.00	HIT designated Assets	476,692	0			7.00	
8.00	Subtotal (sum of lines 1-7)	25,441,777	0			8.00	
9.00	Reconciling Items	0	0			9.00	
10.00	Total (line 8 minus line 9)	25,441,777	0			10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-7
Part II
Date/Time Prepared:
6/19/2017 1:30 pm

Cost Center Description	SUMMARY OF CAPITAL					
	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,149,757	0	167,215	0	0	1.00
3.00	Total (sum of lines 1-2)	1,149,757	0	167,215	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	1,316,972	1.00
3.00	Total (sum of lines 1-2)	0	1,316,972	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-7
Part III
Date/Time Prepared:
6/19/2017 1:30 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	25,441,777	0	25,441,777	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	25,441,777	0	25,441,777	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,139,170	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,139,170	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	165,935	20,640	0	0	1,325,745	1.00
3.00	Total (sum of lines 1-2)	165,935	20,640	0	0	1,325,745	3.00

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.	
			3.00	4.00	5.00	
1.00	2.00	3.00	4.00	5.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			*** Cost Center Deleted ***	2.00	0	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	-561,947			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests		0		0.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts		0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist			*** Cost Center Deleted ***	19.00	0	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		OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-8

Date/Time Prepared:
6/19/2017 1:30 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-10,587	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00 CAFETERIA VENDING - OTHER REV	B	-65,635	DIETARY	10.00	0	33.00
34.00 EMPLOYEE RX PROGRAM -OTHER REV	B	-119,375	DRUGS CHARGED TO PATIENTS	73.00	0	34.00
35.00 MEDICAL RECORDS FEES -OTHER REV	B	-6,086	MEDICAL RECORDS & LIBRARY	16.00	0	35.00
36.00 SALE OF SCRAP -OTHER REV	B	-403	CENTRAL SERVICES & SUPPLY	14.00	0	36.00
37.00 REBATES & REFUNDS - OTHER REV	B	-22,736	CENTRAL SERVICES & SUPPLY	14.00	0	37.00
38.00 BABY PHOTO - OTHER REV	B	-20	ADMINISTRATIVE & GENERAL	5.00	0	38.00
40.00 OTHER SERVICES -OTHER REV	B	-35,801	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00 ICG - OTHER REV	B	-964	ADMINISTRATIVE & GENERAL	5.00	0	41.00
43.00 INVEST INC/UNRESTRICT- INT EXP	A	-1,280	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	43.00
44.00 NONOPERATING - OTHER EXP	A	5,114	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00 BANK FEES -OTHER EXP	A	87,014	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.02 TELEVISION	A	-278	OPERATION OF PLANT	7.00	0	45.02
45.03 PHYSICIAN RECRUITMENT- ADMIN	A	-27,943	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04 LOBBYING EXPENSE	A	-2,798	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05 CRNA	A	-614,256	ANESTHESIOLOGY	53.00	0	45.05
45.06 HOSPITAL ASSESSMENT FEE EXPENSE	A	-257,811	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07		0		0.00	0	45.07
45.08		0		0.00	0	45.08
45.09		0		0.00	0	45.09
45.10		0		0.00	0	45.10
45.11		0		0.00	0	45.11
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,635,792				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-8-2

Date/Time Prepared:
6/19/2017 1:30 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	800,000	0	800,000	0	0	1.00
2.00	60.00	LABORATORY	24,000	0	24,000	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	34,500	0	34,500	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	6,164	6,164	0	0	0	5.00
6.00	90.00	CLINIC	75,000	0	75,000	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	78,552	78,552	0	0	0	7.00
8.00	50.00	OPERATING ROOM	285,999	285,999	0	0	0	8.00
9.00	30.00	ADULTS & PEDIATRICS	191,232	191,232	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,495,447	561,947	933,500			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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	7.00
8.00	50.00	OPERATING ROOM	0	0	0	0	0	8.00
9.00	30.00	ADULTS & PEDIATRICS	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	91.00	EMERGENCY	0	0	0	0		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0		3.00
4.00	90.00	CLINIC	0	0	0	0		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	6,164		5.00
6.00	90.00	CLINIC	0	0	0	0		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	78,552		7.00
8.00	50.00	OPERATING ROOM	0	0	0	285,999		8.00
9.00	30.00	ADULTS & PEDIATRICS	0	0	0	191,232		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	561,947		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/19/2017 1:30 pm		
			Speech Pathology	Cost		
			1.00			
PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)			4	1.00	
2.00	Line 1 multiplied by 15 hours per week			60	2.00	
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)			5	3.00	
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)			0	4.00	
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)			0	5.00	
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)			0	6.00	
7.00	Standard travel expense rate			0.00	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	14.25	0.00	0.00	0.00
10.00	AHSEA (see instructions)	0.00	72.88	0.00	0.00	0.00
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)	36.44	36.44	0.00		
12.00	Number of travel hours (provider site)	0	0	0		12.00
12.01	Number of travel hours (offsite)	0	0	0		12.01
13.00	Number of miles driven (provider site)	0	0	0		13.00
13.01	Number of miles driven (offsite)	0	0	0		13.01
				1.00		
Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)			0	14.00	
15.00	Therapists (column 2, line 9 times column 2, line 10)			1,039	15.00	
16.00	Assistants (column 3, line 9 times column 3, line 10)			0	16.00	
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)			1,039	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)			1,039	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)			72.91	21.00	
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)			4,375	22.00	
23.00	Total salary equivalency (see instructions)			4,375	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)			182	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)			182	26.00	
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)			0	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)			182	28.00	
Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)			0	29.00	
30.00	Assistants (column 3, line 10 times column 3, line 12)			0	30.00	
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)			0	31.00	
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)			0	32.00	
33.00	Standard travel allowance and standard travel expense (line 28)			0	33.00	
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)			0	34.00	
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)			0	35.00	
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)			0	36.00	
37.00	Assistants (line 6 times column 3, line 11)			0	37.00	
38.00	Subtotal (sum of lines 36 and 37)			0	38.00	
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)			0	39.00	
Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)			0	40.00	
41.00	Assistants (column 3, line 12.01 times column 3, line 10)			0	41.00	
42.00	Subtotal (sum of lines 40 and 41)			0	42.00	
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)			0	43.00	
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)			0	44.00	
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: 15-1305		Period: From 10/01/2014 To 09/30/2015		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/19/2017 1:30 pm		
						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	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	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)	72.88	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)					4,375	57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00	
60.00	Overtime allowance (from column 5, line 56)					0	60.00	
61.00	Equipment cost (see instructions)					0	61.00	
62.00	Supplies (see instructions)					0	62.00	
63.00	Total allowance (sum of lines 57-62)					4,375	63.00	
64.00	Total cost of outside supplier services (from your records)					812	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					182	100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27					182	100.02	
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01	
101.02	Line 34 = sum of lines 27 and 31					0	101.02	
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01	
102.02	Line 35 = sum of lines 31 and 32					0	102.02	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part I
Date/Time Prepared:
6/19/2017 1:30 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,325,745	1,325,745				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,739,144	18,207	4,757,351			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,236,268	282,511	640,982	4,159,761	4,159,761	5.00
7.00 00700	OPERATION OF PLANT	724,462	104,624	83,469	912,555	159,367	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	58,984	10,340	6,078	75,402	13,168	8.00
9.00 00900	HOUSEKEEPING	208,502	6,338	48,344	263,184	45,962	9.00
10.00 01000	DIETARY	281,146	51,273	56,595	389,014	67,937	10.00
13.00 01300	NURSING ADMINISTRATION	393,314	12,127	128,042	533,483	93,166	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	46,242	16,696	15,196	78,134	13,645	14.00
15.00 01500	PHARMACY	0	13,312	0	13,312	2,325	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	296,071	25,181	84,669	405,921	70,889	16.00
17.00 01700	SOCIAL SERVICE	49,607	0	17,238	66,845	11,674	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	1,622,397	151,328	627,714	2,401,439	419,383	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00 04300	NURSERY	85,497	2,765	28,651	116,913	20,417	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	619,138	89,869	275,486	984,493	171,930	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	87,279	6,716	29,230	123,225	21,520	52.00
53.00 05300	ANESTHESIOLOGY	18,865	1,769	0	20,634	3,603	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,405,403	61,682	231,336	1,698,421	296,609	54.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	1,131,627	23,876	186,053	1,341,556	234,287	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	81,975	721	0	82,696	14,442	63.00
65.00 06500	RESPIRATORY THERAPY	256,628	13,449	81,562	351,639	61,410	65.00
66.00 06600	PHYSICAL THERAPY	497,840	30,386	168,854	697,080	121,737	66.00
67.00 06700	OCCUPATIONAL THERAPY	74,177	0	25,601	99,778	17,425	67.00
68.00 06800	SPEECH PATHOLOGY	114,616	0	37,128	151,744	26,500	68.00
69.00 06900	ELECTROCARDIOLOGY	29,296	0	9,407	38,703	6,759	69.00
69.01 06901	CARDIAC REHABILITATION	63,825	7,695	20,007	91,527	15,984	69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	399,152	0	0	399,152	69,707	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	314,756	0	0	314,756	54,968	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,673,194	0	0	1,673,194	292,203	73.00
76.00 03020	ONCOLOGY	125,684	9,688	30,176	165,548	28,911	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	3,334,469	140,816	1,055,227	4,530,512	791,192	88.00
90.00 09000	CLINIC	306,872	31,176	26,792	364,840	63,715	90.00
91.00 09100	EMERGENCY	1,725,425	91,055	295,328	2,111,808	368,802	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	521,492	9,001	146,334	676,827	118,200	101.00
SPECIAL PURPOSE COST CENTERS							
116.00 11600	HOSPICE	42,553	3,281	13,800	59,634	10,414	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	25,891,645	1,215,882	4,369,299	25,393,730	3,708,251	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,747	0	7,747	1,353	190.00
190.01 19001	HOMECARE	73,657	2,061	20,398	96,116	16,786	190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,708,052	100,055	340,831	2,148,938	375,286	192.00
194.00 07950	MARKETING	305,777	0	26,823	332,600	58,085	194.00
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)	27,979,131	1,325,745	4,757,351	27,979,131	4,159,761	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part I
Date/Time Prepared:
6/19/2017 1:30 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATIVE	
		7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	1,071,922				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,560	100,130			8.00
9.00	00900	HOUSEKEEPING	7,086	0	316,232		9.00
10.00	01000	DIETARY	57,320	0	17,210	531,481	10.00
13.00	01300	NURSING ADMINISTRATION	13,557	0	4,070	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,665	0	5,604	0	14.00
15.00	01500	PHARMACY	14,882	0	4,468	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,151	0	8,452	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	169,179	35,099	50,794	531,481	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
43.00	04300	NURSERY	3,092	1,978	928	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	100,469	23,068	30,165	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,508	0	2,254	0	52.00
53.00	05300	ANESTHESIOLOGY	1,978	0	594	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	68,957	12,324	20,704	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	26,692	386	8,014	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	807	0	242	0	63.00
65.00	06500	RESPIRATORY THERAPY	15,036	0	4,514	0	65.00
66.00	06600	PHYSICAL THERAPY	45,396	9,608	13,629	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	8,603	0	2,583	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	ONCOLOGY	10,830	213	3,252	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	157,425	1,052	47,265	0	88.00
90.00	09000	CLINIC	34,853	0	10,464	0	90.00
91.00	09100	EMERGENCY	101,794	15,686	30,562	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	10,062	0	3,021	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	3,668	0	1,101	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	917,570	99,414	269,890	531,481	644,276
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,660	0	2,600	0	190.00
190.01	19001	HOMECARE	2,304	0	692	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	143,388	716	43,050	0	192.00
194.00	07950	MARKETING	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,071,922	100,130	316,232	531,481	644,276

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part I
Date/Time Prepared:
6/19/2017 1:30 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal		
		14.00	15.00	16.00	17.00	24.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT					7.00	
8.00	00800	LAUNDRY & LINEN SERVICE					8.00	
9.00	00900	HOUSEKEEPING					9.00	
10.00	01000	DIETARY					10.00	
13.00	01300	NURSING ADMINISTRATION					13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	119,438				14.00	
15.00	01500	PHARMACY	0	34,987			15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	513,413		16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	78,519	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	18,575	72,450	4,043,746	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	1,102	0	162,645	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	53,305	5,182	1,447,155	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	2,951	0	177,528	52.00
53.00	05300	ANESTHESIOLOGY	0	0	9,335	0	36,144	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	110,003	0	2,223,862	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	93,071	0	1,704,006	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	2,183	0	100,370	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	11,821	0	459,103	65.00
66.00	06600	PHYSICAL THERAPY	0	0	18,381	0	905,831	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,766	0	119,969	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,937	0	180,181	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	4,014	0	52,076	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	1,039	0	137,243	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	95,704	0	22,019	0	586,582	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,734	0	5,461	0	398,919	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,987	77,318	0	2,077,702	73.00
76.00	03020	ONCOLOGY	0	0	1,994	0	234,647	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	29,817	0	5,557,263	88.00
90.00	09000	CLINIC	0	0	2,795	0	491,164	90.00
91.00	09100	EMERGENCY	0	0	36,293	0	2,753,627	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	6,924	0	815,034	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	309	887	76,013	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	119,438	34,987	513,413	78,519	24,740,810	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	20,360	190.00
190.01	19001	HEMOCARE	0	0	0	0	115,898	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	2,711,378	192.00
194.00	07950	MARKETING	0	0	0	0	390,685	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	119,438	34,987	513,413	78,519	27,979,131	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part I
Date/Time Prepared:
6/19/2017 1:30 pm

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
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0 4,043,746	30.00
31.00	03100	INTENSIVE CARE UNIT	0 0	31.00
43.00	04300	NURSERY	0 162,645	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0 1,447,155	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0 177,528	52.00
53.00	05300	ANESTHESIOLOGY	0 36,144	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0 2,223,862	54.00
59.00	05900	CARDIAC CATHETERIZATION	0 0	59.00
60.00	06000	LABORATORY	0 1,704,006	60.00
60.01	06001	BLOOD LABORATORY	0 0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0 100,370	63.00
65.00	06500	RESPIRATORY THERAPY	0 459,103	65.00
66.00	06600	PHYSICAL THERAPY	0 905,831	66.00
67.00	06700	OCCUPATIONAL THERAPY	0 119,969	67.00
68.00	06800	SPEECH PATHOLOGY	0 180,181	68.00
69.00	06900	ELECTROCARDIOLOGY	0 52,076	69.00
69.01	06901	CARDIAC REHABILITATION	0 137,243	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0 0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0 586,582	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0 398,919	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0 2,077,702	73.00
76.00	03020	ONCOLOGY	0 234,647	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0 5,557,263	88.00
90.00	09000	CLINIC	0 491,164	90.00
91.00	09100	EMERGENCY	0 2,753,627	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0 0	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0 815,034	101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0 76,013	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0 24,740,810	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 20,360	190.00
190.01	19001	HOMECARE	0 115,898	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0 2,711,378	192.00
194.00	07950	MARKETING	0 390,685	194.00
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 27,979,131	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet B Part II Date/Time Prepared: 6/19/2017 1:30 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	18,207	18,207	18,207	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	282,511	282,511	2,453	5.00
7.00	00700	OPERATION OF PLANT	0	104,624	104,624	319	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,340	10,340	23	8.00
9.00	00900	HOUSEKEEPING	0	6,338	6,338	185	9.00
10.00	01000	DIETARY	0	51,273	51,273	217	10.00
13.00	01300	NURSING ADMINISTRATION	0	12,127	12,127	490	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,696	16,696	58	14.00
15.00	01500	PHARMACY	0	13,312	13,312	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,181	25,181	324	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	66	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	151,328	151,328	2,403	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
43.00	04300	NURSERY	0	2,765	2,765	110	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	89,869	89,869	1,054	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,716	6,716	112	52.00
53.00	05300	ANESTHESIOLOGY	0	1,769	1,769	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	61,682	61,682	885	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	23,876	23,876	712	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	721	721	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	13,449	13,449	312	65.00
66.00	06600	PHYSICAL THERAPY	0	30,386	30,386	646	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	98	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	142	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	36	69.00
69.01	06901	CARDIAC REHABILITATION	0	7,695	7,695	77	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	9,688	9,688	115	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	140,816	140,816	4,038	88.00
90.00	09000	CLINIC	0	31,176	31,176	103	90.00
91.00	09100	EMERGENCY	0	91,055	91,055	1,130	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	9,001	9,001	560	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	3,281	3,281	53	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,215,882	1,215,882	16,721	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,747	7,747	0	190.00
190.01	19001	HOME CARE	0	2,061	2,061	78	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	100,055	100,055	1,305	192.00
194.00	07950	MARKETING	0	0	0	103	194.00
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)	0	1,325,745	1,325,745	18,207	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part II
Date/Time Prepared:
6/19/2017 1:30 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	115,861				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,249	12,514			8.00
9.00	00900	HOUSEKEEPING	766	0	10,438		9.00
10.00	01000	DIETARY	6,196	0	568	62,908	10.00
13.00	01300	NURSING ADMINISTRATION	1,465	0	134	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,017	0	185	0	14.00
15.00	01500	PHARMACY	1,609	0	147	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,043	0	279	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	18,286	4,387	1,677	62,908	11,042
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
43.00	04300	NURSERY	334	247	31	0	582
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,859	2,883	996	0	2,511
52.00	05200	DELIVERY ROOM & LABOR ROOM	812	0	74	0	642
53.00	05300	ANESTHESIOLOGY	214	0	20	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,453	1,540	683	0	539
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	2,885	48	265	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	87	0	8	0	0
65.00	06500	RESPIRATORY THERAPY	1,625	0	149	0	469
66.00	06600	PHYSICAL THERAPY	4,907	1,201	450	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	83
69.01	06901	CARDIAC REHABILITATION	930	0	85	0	560
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	ONCOLOGY	1,171	27	107	0	764
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	17,016	132	1,560	0	0
90.00	09000	CLINIC	3,767	0	345	0	464
91.00	09100	EMERGENCY	11,003	1,960	1,009	0	2,835
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,088	0	100	0	0
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	396	0	36	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	99,178	12,425	8,908	62,908	20,599
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	936	0	86	0	0
190.01	19001	HOMECARE	249	0	23	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,498	89	1,421	0	0
194.00	07950	MARKETING	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	115,861	12,514	10,438	62,908	20,599

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part II
Date/Time Prepared:
6/19/2017 1:30 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal		
		14.00	15.00	16.00	17.00	24.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
4.00	00400						4.00	
5.00	00500						5.00	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000						10.00	
13.00	01300						13.00	
14.00	01400	19,999					14.00	
15.00	01500	0	15,227				15.00	
16.00	01600	0	0	33,683			16.00	
17.00	01700	0	0	0	866		17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	0	0	1,219	799	282,780	30.00	
31.00	03100	0	0	0	0	0	31.00	
43.00	04300	0	0	72	0	5,540	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	0	0	3,498	57	123,505	50.00	
52.00	05200	0	0	194	0	10,024	52.00	
53.00	05300	0	0	613	0	2,863	53.00	
54.00	05400	0	0	7,210	0	100,312	54.00	
59.00	05900	0	0	0	0	0	59.00	
60.00	06000	0	0	6,108	0	49,944	60.00	
60.01	06001	0	0	0	0	0	60.01	
63.00	06300	0	0	143	0	1,948	63.00	
65.00	06500	0	0	776	0	20,987	65.00	
66.00	06600	0	0	1,206	0	47,136	66.00	
67.00	06700	0	0	182	0	1,474	67.00	
68.00	06800	0	0	127	0	2,084	68.00	
69.00	06900	0	0	263	0	845	69.00	
69.01	06901	0	0	68	0	10,510	69.01	
70.00	07000	0	0	0	0	0	70.00	
71.00	07100	16,025	0	1,445	0	22,245	71.00	
72.00	07200	3,974	0	358	0	8,098	72.00	
73.00	07300	0	15,227	5,074	0	40,319	73.00	
76.00	03020	0	0	131	0	13,984	76.00	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	0	0	1,957	0	219,711	88.00	
90.00	09000	0	0	183	0	40,403	90.00	
91.00	09100	0	0	2,382	0	136,640	91.00	
92.00	09200						92.00	
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	0	0	454	0	19,301	101.00	
SPECIAL PURPOSE COST CENTERS								
116.00	11600	0	0	20	10	4,509	116.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)						1,165,162	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	0	0	0	0	8,862	190.00	
190.01	19001	0	0	0	0	3,561	190.01	
192.00	19200	0	0	0	0	144,078	192.00	
194.00	07950	0	0	0	0	4,082	194.00	
200.00	Cross Foot Adjustments						0	200.00
201.00	Negative Cost Centers						0	201.00
202.00	TOTAL (sum lines 118-201)						1,325,745	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet B Part II Date/Time Prepared: 6/19/2017 1:30 pm
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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
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0 282,780	30.00
31.00	03100	INTENSIVE CARE UNIT	0 0	31.00
43.00	04300	NURSERY	0 5,540	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0 123,505	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0 10,024	52.00
53.00	05300	ANESTHESIOLOGY	0 2,863	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0 100,312	54.00
59.00	05900	CARDIAC CATHETERIZATION	0 0	59.00
60.00	06000	LABORATORY	0 49,944	60.00
60.01	06001	BLOOD LABORATORY	0 0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0 1,948	63.00
65.00	06500	RESPIRATORY THERAPY	0 20,987	65.00
66.00	06600	PHYSICAL THERAPY	0 47,136	66.00
67.00	06700	OCCUPATIONAL THERAPY	0 1,474	67.00
68.00	06800	SPEECH PATHOLOGY	0 2,084	68.00
69.00	06900	ELECTROCARDIOLOGY	0 845	69.00
69.01	06901	CARDIAC REHABILITATION	0 10,510	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0 0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0 22,245	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0 8,098	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0 40,319	73.00
76.00	03020	ONCOLOGY	0 13,984	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0 219,711	88.00
90.00	09000	CLINIC	0 40,403	90.00
91.00	09100	EMERGENCY	0 136,640	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0 0	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0 19,301	101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0 4,509	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0 1,165,162	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 8,862	190.00
190.01	19001	HOMECARE	0 3,561	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0 144,078	192.00
194.00	07950	MARKETING	0 4,082	194.00
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 1,325,745	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet B-1
Date/Time Prepared:
6/19/2017 1:30 pm

Cost Center Description	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci liatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)		
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00	5A	5.00	7.00		
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	77,182					1.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1,060	13,690,811				4.00	
5.00 00500 ADMINI STRATI VE & GENERAL	16,447	1,844,633	-4,159,761	23,819,370		5.00	
7.00 00700 OPERATION OF PLANT	6,091	240,208	0	912,555	55,821	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	602	17,492	0	75,402	602	8.00	
9.00 00900 HOUSEKEEPING	369	139,125	0	263,184	369	9.00	
10.00 01000 DI ETARY	2,985	162,870	0	389,014	2,985	10.00	
13.00 01300 NURSI NG ADMINI STRATION	706	368,481	0	533,483	706	13.00	
14.00 01400 CENTRAL SERVI CES & SUPPLY	972	43,732	0	78,134	972	14.00	
15.00 01500 PHARMACY	775	0	0	13,312	775	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	1,466	243,662	0	405,921	1,466	16.00	
17.00 01700 SOCI AL SERVI CE	0	49,607	0	66,845	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDI ATRI CS	8,810	1,806,448	0	2,401,439	8,810	30.00	
31.00 03100 INTENSI VE CARE UNIT	0	0	0	0	0	31.00	
43.00 04300 NURSERY	161	82,453	0	116,913	161	43.00	
ANCI LLARY SERVICE COST CENTERS							
50.00 05000 OPERATI NG ROOM	5,232	792,800	0	984,493	5,232	50.00	
52.00 05200 DELI VERY ROOM & LABOR ROOM	391	84,119	0	123,225	391	52.00	
53.00 05300 ANESTHESI OLOGY	103	0	0	20,634	103	53.00	
54.00 05400 RAD I OLOGY-DI AGNOSTI C	3,591	665,745	0	1,698,421	3,591	54.00	
59.00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	1,390	535,427	0	1,341,556	1,390	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	42	0	0	82,696	42	63.00	
65.00 06500 RESPI RATORY THERAPY	783	234,722	0	351,639	783	65.00	
66.00 06600 PHYSI CAL THERAPY	1,769	485,931	0	697,080	2,364	66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0	73,675	0	99,778	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	106,849	0	151,744	0	68.00	
69.00 06900 ELECTROCARDI OLOGY	0	27,073	0	38,703	0	69.00	
69.01 06901 CARDI AC REHABI LI TATI ON	448	57,577	0	91,527	448	69.01	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	399,152	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS	0	0	0	314,756	0	72.00	
73.00 07300 DRUGS CHARGED TO PATI ENTS	0	0	0	1,673,194	0	73.00	
76.00 03020 ONCOLOGY	564	86,840	0	165,548	564	76.00	
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINI C	8,198	3,036,757	0	4,530,512	8,198	88.00	
90.00 09000 CLINI C	1,815	77,104	0	364,840	1,815	90.00	
91.00 09100 EMERGENCY	5,301	849,902	0	2,111,808	5,301	91.00	
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00 10100 HOME HEALTH AGENCY	524	421,122	0	676,827	524	101.00	
SPECI AL PURPOSE COST CENTERS							
116.00 11600 HOSPI CE	191	39,713	0	59,634	191	116.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	70,786	12,574,067	-4,159,761	21,233,969	47,783	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	451	0	0	7,747	451	190.00	
190.01 19001 HOMECARE	120	58,702	0	96,116	120	190.01	
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES	5,825	980,851	0	2,148,938	7,467	192.00	
194.00 07950 MARKETI NG	0	77,191	0	332,600	0	194.00	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers					201.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1,325,745	4,757,351		4,159,761	1,071,922	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	17.176868	0.347485		0.174638	19.202845	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		18,207		284,964	115,861	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.001330		0.011964	2.075581	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet B-1

Date/Time Prepared:
6/19/2017 1:30 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	
		8.00	9.00	10.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800	126,349					8.00
9.00	00900	0	54,850				9.00
10.00	01000	0	2,985	100			10.00
13.00	01300	0	706	0	86,483		13.00
14.00	01400	0	972	0	455	2,871,700	14.00
15.00	01500	0	775	0	0	0	15.00
16.00	01600	0	1,466	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	44,290	8,810	100	46,357	0	30.00
31.00	03100	0	0	0	0	0	31.00
43.00	04300	2,496	161	0	2,445	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	29,108	5,232	0	10,543	0	50.00
52.00	05200	0	391	0	2,694	0	52.00
53.00	05300	0	103	0	0	0	53.00
54.00	05400	15,551	3,591	0	2,261	0	54.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	487	1,390	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	42	0	0	0	63.00
65.00	06500	0	783	0	1,971	0	65.00
66.00	06600	12,124	2,364	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	349	0	69.00
69.01	06901	0	448	0	2,350	0	69.01
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	2,301,055	71.00
72.00	07200	0	0	0	0	570,645	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	269	564	0	3,208	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	1,328	8,198	0	0	0	88.00
90.00	09000	0	1,815	0	1,946	0	90.00
91.00	09100	19,793	5,301	0	11,904	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	524	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	191	0	0	0	116.00
118.00		125,446	46,812	100	86,483	2,871,700	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	451	0	0	0	190.00
190.01	19001	0	120	0	0	0	190.01
192.00	19200	903	7,467	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		100,130	316,232	531,481	644,276	119,438	202.00
203.00		0.792487	5.765397	5,314.810000	7.449742	0.041591	203.00
204.00		12,514	10,438	62,908	20,599	19,999	204.00
205.00		0.099043	0.190301	629.080000	0.238186	0.006964	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet B-1
Date/Time Prepared:
6/19/2017 1:30 pm

Cost Center Description		PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (ALLOCATION OF TIME)	
		15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500	100			15.00
16.00	01600	0	53,655,452		16.00
17.00	01700	0	0	10,001	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	0	1,941,145	9,228	30.00
31.00	03100	0	0	0	31.00
43.00	04300	0	115,131	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	0	5,570,548	660	50.00
52.00	05200	0	308,378	0	52.00
53.00	05300	0	975,539	0	53.00
54.00	05400	0	11,497,567	0	54.00
59.00	05900	0	0	0	59.00
60.00	06000	0	9,726,259	0	60.00
60.01	06001	0	0	0	60.01
63.00	06300	0	228,177	0	63.00
65.00	06500	0	1,235,312	0	65.00
66.00	06600	0	1,920,889	0	66.00
67.00	06700	0	289,102	0	67.00
68.00	06800	0	202,450	0	68.00
69.00	06900	0	419,471	0	69.00
69.01	06901	0	108,532	0	69.01
70.00	07000	0	0	0	70.00
71.00	07100	0	2,301,055	0	71.00
72.00	07200	0	570,645	0	72.00
73.00	07300	100	8,080,062	0	73.00
76.00	03020	0	208,338	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	3,116,003	0	88.00
90.00	09000	0	292,112	0	90.00
91.00	09100	0	3,792,806	0	91.00
92.00	09200				92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	0	723,626	0	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	0	32,305	113	116.00
118.00		100	53,655,452	10,001	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
190.01	19001	0	0	0	190.01
192.00	19200	0	0	0	192.00
194.00	07950	0	0	0	194.00
200.00					200.00
201.00					201.00
202.00		34,987	513,413	78,519	202.00
203.00		349.870000	0.009569	7.851115	203.00
204.00		15,227	33,683	866	204.00
205.00		152.270000	0.000628	0.086591	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet C
Part I
Date/Time Prepared:
6/19/2017 1:30 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	Hospital			
					RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,043,746		4,043,746	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	162,645		162,645	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,447,155		1,447,155	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	177,528		177,528	0	0	52.00
53.00	05300	ANESTHESIOLOGY	36,144		36,144	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,223,862		2,223,862	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,704,006		1,704,006	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	100,370		100,370	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	459,103	0	459,103	0	0	65.00
66.00	06600	PHYSICAL THERAPY	905,831	0	905,831	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	119,969	0	119,969	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	180,181	0	180,181	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	52,076		52,076	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	137,243		137,243	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	586,582		586,582	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	398,919		398,919	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,077,702		2,077,702	0	0	73.00
76.00	03020	ONCOLOGY	234,647		234,647	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,557,263		5,557,263	0	0	88.00
90.00	09000	CLINIC	491,164		491,164	0	0	90.00
91.00	09100	EMERGENCY	2,753,627		2,753,627	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	341,797		341,797	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	815,034		815,034		0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	76,013		76,013		0	116.00
200.00		Subtotal (see instructions)	25,082,607	0	25,082,607	0	0	200.00
201.00		Less Observation Beds	341,797		341,797		0	201.00
202.00		Total (see instructions)	24,740,810	0	24,740,810	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet C
Part I
Date/Time Prepared:
6/19/2017 1:30 pm

			Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient						
	6.00	7.00	8.00					
			9.00	10.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,757,495		1,757,495			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	115,131		115,131			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	790,348	4,780,200	5,570,548	0.259787	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	191,145	117,233	308,378	0.575683	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	107,526	868,013	975,539	0.037050	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	946,192	10,551,375	11,497,567	0.193420	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,505,370	8,220,889	9,726,259	0.175196	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	90,706	137,471	228,177	0.439878	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	978,758	256,554	1,235,312	0.371649	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	305,864	1,615,025	1,920,889	0.471569	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	136,208	152,894	289,102	0.414971	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	33,541	168,909	202,450	0.890002	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	25,147	394,324	419,471	0.124147	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	108,532	108,532	1.264539	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,204,012	1,097,043	2,301,055	0.254919	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	189,773	380,872	570,645	0.699067	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,371,167	4,708,895	8,080,062	0.257139	0.000000	73.00
76.00	03020	ONCOLOGY	0	208,338	208,338	1.126280	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	3,116,003	3,116,003			88.00
90.00	09000	CLINIC	0	292,112	292,112	1.681424	0.000000	90.00
91.00	09100	EMERGENCY	130,365	3,662,441	3,792,806	0.726013	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	183,650	183,650	1.861133	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	723,626	723,626			101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	32,305	32,305			116.00
200.00		Subtotal (see instructions)	11,878,748	41,776,704	53,655,452			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,878,748	41,776,704	53,655,452			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Prepared: 6/19/2017 1:30 pm
		Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	ONCOLOGY	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS				
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: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet C
Part I
Date/Time Prepared:
6/19/2017 1:30 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	4,043,746		4,043,746	0	4,043,746	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300 NURSERY	162,645		162,645	0	162,645	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,447,155		1,447,155	0	1,447,155	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	177,528		177,528	0	177,528	52.00
53.00	05300 ANESTHESIOLOGY	36,144		36,144	0	36,144	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,223,862		2,223,862	0	2,223,862	54.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000 LABORATORY	1,704,006		1,704,006	0	1,704,006	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300 BLOOD STORAGE, PROCESSING & TRANS.	100,370		100,370	0	100,370	63.00
65.00	06500 RESPIRATORY THERAPY	459,103	0	459,103	0	459,103	65.00
66.00	06600 PHYSICAL THERAPY	905,831	0	905,831	0	905,831	66.00
67.00	06700 OCCUPATIONAL THERAPY	119,969	0	119,969	0	119,969	67.00
68.00	06800 SPEECH PATHOLOGY	180,181	0	180,181	0	180,181	68.00
69.00	06900 ELECTROCARDIOLOGY	52,076		52,076	0	52,076	69.00
69.01	06901 CARDIAC REHABILITATION	137,243		137,243	0	137,243	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	586,582		586,582	0	586,582	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	398,919		398,919	0	398,919	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,077,702		2,077,702	0	2,077,702	73.00
76.00	03020 ONCOLOGY	234,647		234,647	0	234,647	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	5,557,263		5,557,263	0	5,557,263	88.00
90.00	09000 CLINIC	491,164		491,164	0	491,164	90.00
91.00	09100 EMERGENCY	2,753,627		2,753,627	0	2,753,627	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	341,797		341,797		341,797	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	815,034		815,034		815,034	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600 HOSPICE	76,013		76,013		76,013	116.00
200.00	Subtotal (see instructions)	25,082,607	0	25,082,607	0	25,082,607	200.00
201.00	Less Observation Beds	341,797		341,797		341,797	201.00
202.00	Total (see instructions)	24,740,810	0	24,740,810	0	24,740,810	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Prepared: 6/19/2017 1:30 pm
		Title XIX	Hospital	Cost

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,757,495		1,757,495	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	31.00
43.00	04300	NURSERY	115,131		115,131	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	790,348	4,780,200	5,570,548	0.259787 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	191,145	117,233	308,378	0.575683 52.00
53.00	05300	ANESTHESIOLOGY	107,526	868,013	975,539	0.037050 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	946,192	10,551,375	11,497,567	0.193420 54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000 59.00
60.00	06000	LABORATORY	1,505,370	8,220,889	9,726,259	0.175196 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	90,706	137,471	228,177	0.439878 63.00
65.00	06500	RESPIRATORY THERAPY	978,758	256,554	1,235,312	0.371649 65.00
66.00	06600	PHYSICAL THERAPY	305,864	1,615,025	1,920,889	0.471569 66.00
67.00	06700	OCCUPATIONAL THERAPY	136,208	152,894	289,102	0.414971 67.00
68.00	06800	SPEECH PATHOLOGY	33,541	168,909	202,450	0.890002 68.00
69.00	06900	ELECTROCARDIOLOGY	25,147	394,324	419,471	0.124147 69.00
69.01	06901	CARDIAC REHABILITATION	0	108,532	108,532	1.264539 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,204,012	1,097,043	2,301,055	0.254919 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	189,773	380,872	570,645	0.699067 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,371,167	4,708,895	8,080,062	0.257139 73.00
76.00	03020	ONCOLOGY	0	208,338	208,338	1.126280 76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,116,003	3,116,003	1.783459 88.00
90.00	09000	CLINIC	0	292,112	292,112	1.681424 90.00
91.00	09100	EMERGENCY	130,365	3,662,441	3,792,806	0.726013 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	183,650	183,650	1.861133 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	723,626	723,626	
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	32,305	32,305	
200.00		Subtotal (see instructions)	11,878,748	41,776,704	53,655,452	
201.00		Less Observation Beds				
202.00		Total (see instructions)	11,878,748	41,776,704	53,655,452	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Prepared: 6/19/2017 1:30 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901 CARDIAC REHABILITATION	0.000000		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020 ONCOLOGY	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part II Date/Time Prepared: 6/19/2017 1:30 pm
Title XVIII			Hospital	Cost

Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	123,505	5,570,548	0.022171	302,806	6,714	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	10,024	308,378	0.032506	2,222	72	52.00
53.00 05300 ANESTHESIOLOGY	2,863	975,539	0.002935	31,996	94	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	100,312	11,497,567	0.008725	411,107	3,587	54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00 06000 LABORATORY	49,944	9,726,259	0.005135	554,734	2,849	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	1,948	228,177	0.008537	52,988	452	63.00
65.00 06500 RESPIRATORY THERAPY	20,987	1,235,312	0.016989	510,849	8,679	65.00
66.00 06600 PHYSICAL THERAPY	47,136	1,920,889	0.024539	66,687	1,636	66.00
67.00 06700 OCCUPATIONAL THERAPY	1,474	289,102	0.005099	30,161	154	67.00
68.00 06800 SPEECH PATHOLOGY	2,084	202,450	0.010294	10,933	113	68.00
69.00 06900 ELECTROCARDIOLOGY	845	419,471	0.002014	20,599	41	69.00
69.01 06901 CARDIAC REHABILITATION	10,510	108,532	0.096838	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22,245	2,301,055	0.009667	266,773	2,579	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	8,098	570,645	0.014191	115,494	1,639	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	40,319	8,080,062	0.004990	1,508,837	7,529	73.00
76.00 03020 ONCOLOGY	13,984	208,338	0.067122	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	219,711	3,116,003	0.070511	0	0	88.00
90.00 09000 CLINIC	40,403	292,112	0.138313	0	0	90.00
91.00 09100 EMERGENCY	136,640	3,792,806	0.036026	8,460	305	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	23,902	183,650	0.130150	0	0	92.00
200.00 Total (lines 50-199)	876,934	51,026,895		3,894,646	36,443	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 6/19/2017 1:30 pm
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Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col 4)
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 6/19/2017 1:30 pm
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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)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	5,570,548	0.000000	0.000000	302,806	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	308,378	0.000000	0.000000	2,222	52.00
53.00	05300	ANESTHESIOLOGY	0	975,539	0.000000	0.000000	31,996	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,497,567	0.000000	0.000000	411,107	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	9,726,259	0.000000	0.000000	554,734	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	228,177	0.000000	0.000000	52,988	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,235,312	0.000000	0.000000	510,849	65.00
66.00	06600	PHYSICAL THERAPY	0	1,920,889	0.000000	0.000000	66,687	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	289,102	0.000000	0.000000	30,161	67.00
68.00	06800	SPEECH PATHOLOGY	0	202,450	0.000000	0.000000	10,933	68.00
69.00	06900	ELECTROCARDIOLOGY	0	419,471	0.000000	0.000000	20,599	69.00
69.01	06901	CARDIAC REHABILITATION	0	108,532	0.000000	0.000000	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,301,055	0.000000	0.000000	266,773	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	570,645	0.000000	0.000000	115,494	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,080,062	0.000000	0.000000	1,508,837	73.00
76.00	03020	ONCOLOGY	0	208,338	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	3,116,003	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	292,112	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	3,792,806	0.000000	0.000000	8,460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	183,650	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	51,026,895			3,894,646	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 6/19/2017 1:30 pm
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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)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901 CARDIAC REHABILITATION	0	0	0		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020 ONCOLOGY	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Prepared: 6/19/2017 1:30 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.259787	0	1,757,995	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.575683	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.037050	0	316,277	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.193420	0	3,810,395	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.175196	0	3,685,475	0	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.439878	0	34,119	0	0
65.00 06500 RESPIRATORY THERAPY	0.371649	0	199,827	0	0
66.00 06600 PHYSICAL THERAPY	0.471569	0	491,971	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.414971	0	23,594	0	0
68.00 06800 SPEECH PATHOLOGY	0.890002	0	6,802	0	0
69.00 06900 ELECTROCARDIOLOGY	0.124147	0	91,828	0	0
69.01 06901 CARDIAC REHABILITATION	1.264539	0	51,532	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.254919	0	470,142	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.699067	0	162,409	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.257139	0	2,338,539	70	0
76.00 03020 ONCOLOGY	1.126280	0	136,590	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
90.00 09000 CLINIC	1.681424	0	180,704	0	0
91.00 09100 EMERGENCY	0.726013	0	1,141,338	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.861133	0	65,315	0	0
200.00 Subtotal (see instructions)		0	14,964,852	70	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	14,964,852	70	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Prepared: 6/19/2017 1:30 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	456,704	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	11,718	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	737,007	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	645,680	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	15,008	0	63.00
65.00	06500	RESPIRATORY THERAPY	74,266	0	65.00
66.00	06600	PHYSICAL THERAPY	231,998	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,791	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,054	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,400	0	69.00
69.01	06901	CARDIAC REHABILITATION	65,164	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	119,848	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	113,535	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	601,330	18	73.00
76.00	03020	ONCOLOGY	153,839	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	303,840	0	90.00
91.00	09100	EMERGENCY	828,626	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	121,560	0	92.00
200.00		Subtotal (see instructions)	4,507,368	18	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	4,507,368	18	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-1305 Component CCN: 15-Z305	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Prepared: 6/19/2017 1:30 pm
Title XVIII			Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.259787	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.575683	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.037050	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.193420	0	0	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000 LABORATORY	0.175196	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.439878	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.371649	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.471569	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.414971	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.890002	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.124147	0	0	0	69.00
69.01	06901 CARDIAC REHABILITATION	1.264539	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.254919	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.699067	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.257139	0	0	0	73.00
76.00	03020 ONCOLOGY	1.126280	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
90.00	09000 CLINIC	1.681424	0	0	0	90.00
91.00	09100 EMERGENCY	0.726013	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.861133	0	0	0	92.00
200.00	Subtotal (see instructions)		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	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1305 Component CCN: 15-Z305	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Prepared: 6/19/2017 1:30 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	ONCOLOGY	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 6/19/2017 1:30 pm
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,975	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,123	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,885	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		70	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)		607	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		40	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)		135	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,058	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)		70	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)		607	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		129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,043,746	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		5,166	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)		17,434	25.00
26.00	Total swing-bed cost (see instructions)		994,853	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,048,893	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)		3,048,893	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)		1,436.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,519,415	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,519,415	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet D-1
Date/Time Prepared:
6/19/2017 1:30 pm

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	0	0	0.00	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)					1,070,115	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,589,530	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)					100,528	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					871,725	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					972,253	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)					238	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,436.12	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					341,797	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1305		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1 Date/Time Prepared: 6/19/2017 1:30 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	282,780	4,043,746	0.069930	341,797	23,902	90.00
91.00	Nursing School cost	0	4,043,746	0.000000	341,797	0	91.00
92.00	Allied health cost	0	4,043,746	0.000000	341,797	0	92.00
93.00	All other Medical Education	0	4,043,746	0.000000	341,797	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 6/19/2017 1:30 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,975 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,123 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,885 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			677 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			175 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			77 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			198 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,043,746	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		977,723	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,066,023	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)		3,066,023	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)		1,444,20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		111,203	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)		111,203	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 6/19/2017 1:30 pm	
Title XIX			Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	162,645	198	821.44	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	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)					83,734	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					194,937	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					238	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,444.19	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					343,717	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1305		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1 Date/Time Prepared: 6/19/2017 1:30 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	282,780	4,043,746	0.069930	343,717	24,036	90.00
91.00	Nursing School cost	0	4,043,746	0.000000	343,717	0	91.00
92.00	Allied health cost	0	4,043,746	0.000000	343,717	0	92.00
93.00	All other Medical Education	0	4,043,746	0.000000	343,717	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet D-3 Date/Time Prepared: 6/19/2017 1:30 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		855,391		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	0.259787	302,806	78,665	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.575683	2,222	1,279	52.00
53.00	05300 ANESTHESIOLOGY	0.037050	31,996	1,185	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.193420	411,107	79,516	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.175196	554,734	97,187	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.439878	52,988	23,308	63.00
65.00	06500 RESPIRATORY THERAPY	0.371649	510,849	189,857	65.00
66.00	06600 PHYSICAL THERAPY	0.471569	66,687	31,448	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.414971	30,161	12,516	67.00
68.00	06800 SPEECH PATHOLOGY	0.890002	10,933	9,730	68.00
69.00	06900 ELECTROCARDIOLOGY	0.124147	20,599	2,557	69.00
69.01	06901 CARDIAC REHABILITATION	1.264539	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.254919	266,773	68,006	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.699067	115,494	80,738	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.257139	1,508,837	387,981	73.00
76.00	03020 ONCOLOGY	1.126280	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	1.681424	0	0	90.00
91.00	09100 EMERGENCY	0.726013	8,460	6,142	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.861133	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		3,894,646	1,070,115	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		3,894,646		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1305 Component CCN: 15-Z305	Period: From 10/01/2014 To 09/30/2015	Worksheet D-3 Date/Time Prepared: 6/19/2017 1:30 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		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	0.259787	12,761	3,315	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.575683	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.037050	670	25	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.193420	28,701	5,551	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.175196	112,452	19,701	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.439878	4,208	1,851	63.00
65.00	06500 RESPIRATORY THERAPY	0.371649	168,875	62,762	65.00
66.00	06600 PHYSICAL THERAPY	0.471569	162,688	76,719	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.414971	70,347	29,192	67.00
68.00	06800 SPEECH PATHOLOGY	0.890002	2,249	2,002	68.00
69.00	06900 ELECTROCARDIOLOGY	0.124147	312	39	69.00
69.01	06901 CARDIAC REHABILITATION	1.264539	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.254919	46,770	11,923	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.699067	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.257139	118,301	30,420	73.00
76.00	03020 ONCOLOGY	1.126280	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	1.681424	0	0	90.00
91.00	09100 EMERGENCY	0.726013	94	68	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.861133	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		728,428	243,568	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		728,428		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet D-3 Date/Time Prepared: 6/19/2017 1:30 pm	
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		39,205	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
43.00	04300	NURSERY		17,687	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.259787	34,784	9,036 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.575683	25,768	14,834 52.00
53.00	05300	ANESTHESIOLOGY	0.037050	6,398	237 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.193420	25,318	4,897 54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.175196	38,274	6,705 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.439878	2,659	1,170 63.00
65.00	06500	RESPIRATORY THERAPY	0.371649	14,211	5,282 65.00
66.00	06600	PHYSICAL THERAPY	0.471569	1,157	546 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.414971	518	215 67.00
68.00	06800	SPEECH PATHOLOGY	0.890002	2,444	2,175 68.00
69.00	06900	ELECTROCARDIOLOGY	0.124147	493	61 69.00
69.01	06901	CARDIAC REHABILITATION	1.264539	0	0 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.254919	34,951	8,910 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.699067	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257139	90,746	23,334 73.00
76.00	03020	ONCOLOGY	1.126280	0	0 76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1.783459	0	0 88.00
90.00	09000	CLINIC	1.681424	0	0 90.00
91.00	09100	EMERGENCY	0.726013	8,722	6,332 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.861133	0	0 92.00
200.00		Total (sum of lines 50-94 and 96-98)		286,443	83,734 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		286,443	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1305 Component CCN: 15-Z305	Period: From 10/01/2014 To 09/30/2015	Worksheet D-3 Date/Time Prepared: 6/19/2017 1:30 pm
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
43.00	04300 NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.259787	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.575683	0	52.00
53.00	05300 ANESTHESIOLOGY	0.037050	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.193420	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000 LABORATORY	0.175196	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.439878	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.371649	0	65.00
66.00	06600 PHYSICAL THERAPY	0.471569	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.414971	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.890002	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.124147	0	69.00
69.01	06901 CARDIAC REHABILITATION	1.264539	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.254919	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.699067	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.257139	0	73.00
76.00	03020 ONCOLOGY	1.126280	0	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	1.783459	0	88.00
90.00	09000 CLINIC	1.681424	0	90.00
91.00	09100 EMERGENCY	0.726013	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.861133	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 6/19/2017 1:30 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,507,386 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4,507,386 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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			4,552,460 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			40,880 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,281,157 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)			2,230,423 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)			2,230,423 30.00
31.00	Primary payer payments			1,489 31.00
32.00	Subtotal (line 30 minus line 31)			2,228,934 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)			442,028 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			287,318 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			421,975 36.00
37.00	Subtotal (see instructions)			2,516,252 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)			2,516,252 40.00
40.01	Sequestration adjustment (see instructions)			50,325 40.01
41.00	Interim payments			2,530,243 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-64,316 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: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet E-1
Part I
Date/Time Prepared:
6/19/2017 1:30 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,001,482		2,530,243	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,001,482		2,530,243	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		303,335		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		64,316	6.02	
7.00	Total Medicare program liability (see instructions)		2,304,817		2,465,927	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1305
Component CCN: 15-Z305

Period:
From 10/01/2014
To 09/30/2015

Worksheet E-1
Part I
Date/Time Prepared:
6/19/2017 1:30 pm

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		994,040		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		994,040		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		191,789		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,185,829		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet E-1 Part II Date/Time Prepared: 6/19/2017 1:30 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			590 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			1,058 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			74 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			1,885 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			53,655,452 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			396,501 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			0 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			0 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1305

Period:

Worksheet E-2

Component CCN: 15-Z305

From 10/01/2014
To 09/30/2015

Date/Time Prepared:
6/19/2017 1:30 pm

		Title XVIII		Swing Beds - SNF	Cost
		Part A	Part B		
		1.00	2.00		
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	981,976	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)	246,004	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	677	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)	1,227,980	0		8.00
9.00	Primary payer payments (see instructions)	0	0		9.00
10.00	Subtotal (line 8 minus line 9)	1,227,980	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)	1,227,980	0		12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	17,950	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)	1,210,030	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)	1,210,030	0		19.00
19.01	Sequestration adjustment (see instructions)	24,201	0		19.01
20.00	Interim payments	994,040	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)	191,789	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0		23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 15-1305 Component CCN: 15-Z305	Period: From 10/01/2014 To 09/30/2015	Worksheet E-2 Date/Time Prepared: 6/19/2017 1:30 pm
		Title XIX	Swing Beds - SNF	PPS
			Part A	Part B
			1.00	2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0	2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)		0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days		0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	8.00
9.00	Primary payer payments (see instructions)		0	9.00
10.00	Subtotal (line 8 minus line 9)		0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	11.00
12.00	Subtotal (line 10 minus line 11)		0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)		0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT		0	16.55
17.00	Allowable bad debts (see instructions)		0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	18.00
19.00	Total (see instructions)		0	19.00
19.01	Sequestration adjustment (see instructions)		0	19.01
20.00	Interim payments		0	20.00
21.00	Tentative settlement (for contractor use only)		0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part V Date/Time Prepared: 6/19/2017 1:30 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			2,589,530 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			2,589,530 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,615,425 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,615,425 19.00
20.00	Deductibles (exclude professional component)			278,793 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			2,336,632 22.00
23.00	Coinurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			2,336,632 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			23,419 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			15,222 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			18,546 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,351,854 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (see instructions)			2,351,854 30.00
30.01	Sequestration adjustment (see instructions)			47,037 30.01
31.00	Interim payments			2,001,482 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)			303,335 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1305	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part VII Date/Time Prepared: 6/19/2017 1:30 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		194,937		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		194,937	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		194,937	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		56,892		8.00
9.00	Ancillary service charges		286,443	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		343,335	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		343,335	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		148,398	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		194,937	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		194,937	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		194,937	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		194,937	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		194,937	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		194,937	0	40.00
41.00	Interim payments		122,927	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		72,010	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet G
Date/Time Prepared:
6/19/2017 1:30 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,468,139	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	4,445,120	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,896,064	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)	7,809,323	0	0	0	11.00
FIXED ASSETS						
12.00	Land	672,217	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	8,076,315	0	0	0	15.00
16.00	Accumulated depreciation	0	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)	8,748,532	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	500,000	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	232,315	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	732,315	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	17,290,170	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,442,788	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,565,975	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	982,149	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	341,689	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,332,601	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,350,672	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	27,474	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,378,146	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,710,747	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	9,579,423	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	9,579,423	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	17,290,170	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet G-1

Date/Time Prepared:
6/19/2017 1:30 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		9,636,312		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-56,889				2.00
3.00	Total (sum of line 1 and line 2)		9,579,423		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)		9,579,423		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,579,423		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet G-2
Parts I & II
Date/Time Prepared:
6/19/2017 1:30 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,872,626		1,872,626	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)	1,872,626		1,872,626	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,872,626		1,872,626	17.00
18.00	Ancillary services	9,865,757	33,776,567	43,642,324	18.00
19.00	Outpatient services	130,365	4,138,203	4,268,568	19.00
20.00	RURAL HEALTH CLINIC	0	3,116,003	3,116,003	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		723,626	723,626	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	32,305	32,305	26.00
27.00	PHYSICIAN PRIVATE OFFICE	254,706	2,208,098	2,462,804	27.00
27.01	PRO FEES	16,106	354	16,460	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,139,560	43,995,156	56,134,716	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		29,614,923		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		29,614,923		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-1305

Period:
From 10/01/2014
To 09/30/2015

Worksheet G-3

Date/Time Prepared:
6/19/2017 1:30 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	56,134,716	1.00
2.00	Less contractual allowances and discounts on patients' accounts	27,198,765	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,935,951	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	29,614,923	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-678,972	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	594,067	24.00
24.01	NONOPERATING REVENUE	18,516	24.01
25.00	Total other income (sum of lines 6-24)	612,583	25.00
26.00	Total (line 5 plus line 25)	-66,389	26.00
27.00	RECONCILING ITEM	-9,500	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-9,500	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-56,889	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS				Provider CCN: 15-1305 HHA CCN: 15-7078	Period: From 10/01/2014 To 09/30/2015	Worksheet H Date/Time Prepared: 6/19/2017 1:30 pm
					Home Health Agency I	PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 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	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	91,046	0	55,432	0	44,939	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	220,708	0	0	0	220,708	6.00
7.00	Physical Therapy	56,242	0	0	0	56,242	7.00
8.00	Occupational Therapy	14,018	0	0	0	14,018	8.00
9.00	Speech Pathology	5,182	0	0	0	5,182	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	86,496	0	0	0	86,496	11.00
12.00	Supplies (see instructions)	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	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	473,692	0	55,432	0	44,939	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	-52,571	138,846	0	138,846		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	220,708	0	220,708		6.00
7.00	Physical Therapy	0	56,242	0	56,242		7.00
8.00	Occupational Therapy	0	14,018	0	14,018		8.00
9.00	Speech Pathology	0	5,182	0	5,182		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Home Health Aide	0	86,496	0	86,496		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
23.50	Tel emedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	-52,571	521,492	0	521,492		24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 15-1305 HHA CCN: 15-7078	Period: From 10/01/2014 To 09/30/2015	Worksheet H-1 Part I Date/Time Prepared: 6/19/2017 1:30 pm
			Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
	0	1.00	2.00	3.00	4.00	4A.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0		0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	138,846	0	0	0	138,846	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	220,708	0	0	0	220,708	6.00
7.00	Physical Therapy	56,242	0	0	0	56,242	7.00
8.00	Occupational Therapy	14,018	0	0	0	14,018	8.00
9.00	Speech Pathology	5,182	0	0	0	5,182	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	86,496	0	0	0	86,496	11.00
12.00	Supplies (see instructions)	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	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	521,492	0	0	0	521,492	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	138,846					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	80,085	300,793				6.00
7.00	Physical Therapy	20,408	76,650				7.00
8.00	Occupational Therapy	5,087	19,105				8.00
9.00	Speech Pathology	1,880	7,062				9.00
10.00	Medical Social Services	0	0				10.00
11.00	Home Health Aide	31,386	117,882				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
23.50	Tel emedicine	0	0				23.50
24.00	Total (sum of lines 1-23)		521,492				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-1305
HHA CCN: 15-7078

Period:
From 10/01/2014
To 09/30/2015

Worksheet H-1
Part II
Date/Time Prepared:
6/19/2017 1:30 pm

Home Health Agency I
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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
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	-138,846	382,646
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	220,708
7.00	Physical Therapy	0	0	0	0	0	56,242
8.00	Occupational Therapy	0	0	0	0	0	14,018
9.00	Speech Pathology	0	0	0	0	0	5,182
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	0	0	0	0	0	86,496
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-138,846	382,646
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	0	138,846
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.362858

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1305

Period: From 10/01/2014

Worksheet H-2

HHA CCN: 15-7078

To 09/30/2015

Part I
Date/Time Prepared:
6/19/2017 1:30 pm

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		NEW BLDG & FIXT						
	0	1.00		4.00	4A	5.00	7.00	
1.00 Administrative and General	0	9,001		146,334	155,335	27,127	10,062	1.00
2.00 Skilled Nursing Care	300,793	0		0	300,793	52,531	0	2.00
3.00 Physical Therapy	76,650	0		0	76,650	13,386	0	3.00
4.00 Occupational Therapy	19,105	0		0	19,105	3,336	0	4.00
5.00 Speech Pathology	7,062	0		0	7,062	1,233	0	5.00
6.00 Medical Social Services	0	0		0	0	0	0	6.00
7.00 Home Health Aide	117,882	0		0	117,882	20,587	0	7.00
8.00 Supplies (see instructions)	0	0		0	0	0	0	8.00
9.00 Drugs	0	0		0	0	0	0	9.00
10.00 DME	0	0		0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0		0	0	0	0	11.00
12.00 Respiratory Therapy	0	0		0	0	0	0	12.00
13.00 Private Duty Nursing	0	0		0	0	0	0	13.00
14.00 Clinic	0	0		0	0	0	0	14.00
15.00 Health Promotion Activities	0	0		0	0	0	0	15.00
16.00 Day Care Program	0	0		0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0		0	0	0	0	17.00
18.00 Homemaker Service	0	0		0	0	0	0	18.00
19.00 All Others (specify)	0	0		0	0	0	0	19.00
19.50 Telemedicine	0	0		0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	521,492	9,001		146,334	676,827	118,200	10,062	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	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING	CENTRAL SERVICES & SUPPLY	PHARMACY		
	8.00	9.00	10.00	13.00	14.00	15.00		
1.00 Administrative and General	0	3,021	0	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	0	3,021	0	0	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.								21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1305
HHA CCN: 15-7078

Period:
From 10/01/2014
To 09/30/2015

Worksheet H-2
Part I
Date/Time Prepared:
6/19/2017 1:30 pm

Home Health
Agency I

PPS

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		16.00	17.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	6,924	0	202,469	0	202,469		1.00
2.00	Skilled Nursing Care	0	0	353,324	0	353,324	116,783	2.00
3.00	Physical Therapy	0	0	90,036	0	90,036	29,759	3.00
4.00	Occupational Therapy	0	0	22,441	0	22,441	7,417	4.00
5.00	Speech Pathology	0	0	8,295	0	8,295	2,742	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	138,469	0	138,469	45,768	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Tel emedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	6,924	0	815,034	0	815,034	202,469	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.						0.330527	21.00
Cost Center Description		Total HHA Costs						
		28.00						
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	470,107						2.00
3.00	Physical Therapy	119,795						3.00
4.00	Occupational Therapy	29,858						4.00
5.00	Speech Pathology	11,037						5.00
6.00	Medical Social Services	0						6.00
7.00	Home Health Aide	184,237						7.00
8.00	Supplies (see instructions)	0						8.00
9.00	Drugs	0						9.00
10.00	DME	0						10.00
11.00	Home Dialysis Aide Services	0						11.00
12.00	Respiratory Therapy	0						12.00
13.00	Private Duty Nursing	0						13.00
14.00	Clinic	0						14.00
15.00	Health Promotion Activities	0						15.00
16.00	Day Care Program	0						16.00
17.00	Home Delivered Meals Program	0						17.00
18.00	Homemaker Service	0						18.00
19.00	All Others (specify)	0						19.00
19.50	Tel emedicine	0						19.50
20.00	Total (sum of lines 1-19) (2)	815,034						20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 15-1305 HHA CCN: 15-7078	Period: From 10/01/2014 To 09/30/2015	Worksheet H-2 Part II Date/Time Prepared: 6/19/2017 1:30 pm
		Home Health Agency I	PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
	NEW BLDG & FIXT (SQUARE FEET)							
	1.00	4.00						
1.00 Administrative and General	524		421,122	0	155,335	524	0	1.00
2.00 Skilled Nursing Care	0		0	0	300,793	0	0	2.00
3.00 Physical Therapy	0		0	0	76,650	0	0	3.00
4.00 Occupational Therapy	0		0	0	19,105	0	0	4.00
5.00 Speech Pathology	0		0	0	7,062	0	0	5.00
6.00 Medical Social Services	0		0	0	0	0	0	6.00
7.00 Home Health Aide	0		0	0	117,882	0	0	7.00
8.00 Supplies (see instructions)	0		0	0	0	0	0	8.00
9.00 Drugs	0		0	0	0	0	0	9.00
10.00 DME	0		0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0		0	0	0	0	0	11.00
12.00 Respiratory Therapy	0		0	0	0	0	0	12.00
13.00 Private Duty Nursing	0		0	0	0	0	0	13.00
14.00 Clinic	0		0	0	0	0	0	14.00
15.00 Health Promotion Activities	0		0	0	0	0	0	15.00
16.00 Day Care Program	0		0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0		0	0	0	0	0	17.00
18.00 Homemaker Service	0		0	0	0	0	0	18.00
19.00 All Others (specify)	0		0	0	0	0	0	19.00
19.50 Telemedicine	0		0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	524		421,122	0	676,827	524	0	20.00
21.00 Total cost to be allocated	9,001		146,334	0	118,200	10,062	0	21.00
22.00 Unit cost multiplier	17.177481		0.347486	0	0.174638	19.202290	0.000000	22.00
Cost Center Description	HOUSEKEEPING (SQUARE FEET)		DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
	9.00		10.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	524		0	0	0	0	723,626	1.00
2.00 Skilled Nursing Care	0		0	0	0	0	0	2.00
3.00 Physical Therapy	0		0	0	0	0	0	3.00
4.00 Occupational Therapy	0		0	0	0	0	0	4.00
5.00 Speech Pathology	0		0	0	0	0	0	5.00
6.00 Medical Social Services	0		0	0	0	0	0	6.00
7.00 Home Health Aide	0		0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0		0	0	0	0	0	8.00
9.00 Drugs	0		0	0	0	0	0	9.00
10.00 DME	0		0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0		0	0	0	0	0	11.00
12.00 Respiratory Therapy	0		0	0	0	0	0	12.00
13.00 Private Duty Nursing	0		0	0	0	0	0	13.00
14.00 Clinic	0		0	0	0	0	0	14.00
15.00 Health Promotion Activities	0		0	0	0	0	0	15.00
16.00 Day Care Program	0		0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0		0	0	0	0	0	17.00
18.00 Homemaker Service	0		0	0	0	0	0	18.00
19.00 All Others (specify)	0		0	0	0	0	0	19.00
19.50 Telemedicine	0		0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	524		0	0	0	0	723,626	20.00
21.00 Total cost to be allocated	3,021		0	0	0	0	6,924	21.00
22.00 Unit cost multiplier	5.765267		0.000000	0.000000	0.000000	0.000000	0.009568	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 15-1305 HHA CCN: 15-7078	Period: From 10/01/2014 To 09/30/2015	Worksheet H-2 Part II Date/Time Prepared: 6/19/2017 1:30 pm PPS
		Home Health Agency I	

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

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-1305 HHA CCN: 15-7078	Period: From 10/01/2014 To 09/30/2015	Worksheet H-3 Part I Date/Time Prepared: 6/19/2017 1:30 pm
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		Title XVIII		Home Health Agency I	PPS
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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 (col. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 + col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	470,107		470,107	1,255	374.59	1.00
2.00	Physical Therapy	3.00	119,795	0	119,795	662	180.96	2.00
3.00	Occupational Therapy	4.00	29,858	0	29,858	165	180.96	3.00
4.00	Speech Pathology	5.00	11,037	0	11,037	61	180.93	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	184,237		184,237	2,216	83.14	6.00
7.00	Total (sum of lines 1-6)		815,034	0	815,034	4,359		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits		
			Part A	Part B	
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles
0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	318		8.00
8.01	Skilled Nursing Care		50031	0	860		8.01
9.00	Physical Therapy		99915	0	192		9.00
9.01	Physical Therapy		50031	0	402		9.01
10.00	Occupational Therapy		99915	0	35		10.00
10.01	Occupational Therapy		50031	0	91		10.01
11.00	Speech Pathology		99915	0	42		11.00
11.01	Speech Pathology		50031	0	4		11.01
12.00	Medical Social Services		99915	0	0		12.00
12.01	Medical Social Services		50031	0	0		12.01
13.00	Home Health Aide		99915	0	214		13.00
13.01	Home Health Aide		50031	0	651		13.01
14.00	Total (sum of lines 8-13)			0	2,809		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 (col. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 + col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

Cost Center Description	Part A	Part B		Part A	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		6.00	7.00		8.00	9.00

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	1,178		0	441,267	1.00
2.00	Physical Therapy	0	594		0	107,490	2.00
3.00	Occupational Therapy	0	126		0	22,801	3.00
4.00	Speech Pathology	0	46		0	8,323	4.00
5.00	Medical Social Services	0	0		0	0	5.00
6.00	Home Health Aide	0	865		0	71,916	6.00
7.00	Total (sum of lines 1-6)	0	2,809		0	651,797	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 15-1305	Period: From 10/01/2014	Worksheet H-3
				HHA CCN: 15-7078	To 09/30/2015	Part I
				Title XVIII	Home Health Agency I	Date/Time Prepared: 6/19/2017 1:30 pm
						PPS

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

Cost Center Description		Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		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	15.00	
16.00	Cost of Drugs		0	0		0	16.00	
Total Program Cost (sum of col.s. 9-10)								
		12.00						

Cost Center Description		Total Program Cost (sum of col.s. 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	441,267	1.00
2.00	Physical Therapy	107,490	2.00
3.00	Occupational Therapy	22,801	3.00
4.00	Speech Pathology	8,323	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	71,916	6.00
7.00	Total (sum of lines 1-6)	651,797	7.00

Cost Center Description		12.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-1305 HHA CCN: 15-7078	Period: From 10/01/2014 To 09/30/2015	Worksheet H-3 Part II Date/Time Prepared: 6/19/2017 1:30 pm
Title XVIII			Home Health Agency I	PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.471569	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.414971	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology	68.00	0.890002	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.254919	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.257139	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1305 HHA CCN: 15-7078	Period: From 10/01/2014 To 09/30/2015	Worksheet H-4 Part I-II Date/Time Prepared: 6/19/2017 1:30 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
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
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	385,356
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	0
13.00	Total PPS Reimbursement - LUPA Episodes		0	9,355
14.00	Total PPS Reimbursement - PEP Episodes		0	2,898
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	0
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	397,609
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	397,609
25.00	Coinurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	397,609
27.00	Reimbursable bad debts (from your records)			0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	397,609
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
31.00	Subtotal (see instructions)		0	397,609
31.01	Sequestration adjustment (see instructions)		0	7,952
32.00	Interim payments (see instructions)		0	389,656
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	1
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

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

Provider CCN: 15-1305
HHA CCN: 15-7078

Period: From 10/01/2014 To 09/30/2015

Worksheet H-5
Date/Time Prepared: 6/19/2017 1:30 pm
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		389,656	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		389,656	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		389,657	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 HOSPICE COSTS

Provider CCN: 15-1305

Period: From 10/01/2014

Worksheet K

Hospice CCN: 15-1550

To 09/30/2015

Date/Time Prepared: 6/19/2017 1:30 pm

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	5,212	0	140	0	2,700	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	18,951	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	14,836	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	714	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	39,713	0	140	0	2,700	39.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1305

Period: From 10/01/2014

Worksheet K

Hospice CCN: 15-1550

To 09/30/2015

Date/Time Prepared: 6/19/2017 1:30 pm

		Hospice I					
		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	8,052	0	8,052	0	8,052	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	18,951	0	18,951	0	18,951	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	14,836	0	14,836	0	14,836	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	714	0	714	0	714	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	42,553	0	42,553	0	42,553	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 15-1305

Period: From 10/01/2014

Worksheet K-1

Hospice CCN: 15-1550

To 09/30/2015

Date/Time Prepared: 6/19/2017 1:30 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	5,212	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	18,951	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	5,212	0	0	0	18,951	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 15-1305

Period: From 10/01/2014

Worksheet K-1

Hospice CCN: 15-1550

To 09/30/2015

Date/Time Prepared: 6/19/2017 1:30 pm

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	5,212	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	18,951	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	14,836	0	0	14,836	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	0	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		714	0	714	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	14,836	714	0	39,713	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 15-1305

Period: From 10/01/2014

Worksheet K-4

Hospice CCN: 15-1550

To 09/30/2015

Part I
Date/Time Prepared:
6/19/2017 1:30 pm

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	8,052	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	18,951	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	14,836	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	714	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	42,553	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 15-1305

Period: From 10/01/2014

Worksheet K-4

Hospice CCN: 15-1550

To 09/30/2015

Part I
Date/Time Prepared:
6/19/2017 1:30 pm

		Hospice I				
		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col . 5A ± col . 6)	
		5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance					3.00
4.00	Transportation - Staff					4.00
5.00	Volunteer Service Coordination	0				5.00
6.00	Administrative and General	0	8,052	8,052		6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	0	18,951	4,423	23,374	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	14,836	3,462	18,298	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	714	167	881	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	42,553		42,553	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1305

Period: From 10/01/2014

Worksheet K-4

Hospice CCN: 15-1550

To 09/30/2015

Part II
Date/Time Prepared:
6/19/2017 1:30 pm

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1305

Period: From 10/01/2014

Worksheet K-4

Hospice CCN: 15-1550

To 09/30/2015

Part II
Date/Time Prepared:
6/19/2017 1:30 pm

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	Hospice I
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-8,052	34,501	6.00
INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0	7.00
8.00	Inpatient - Respite Care	0	0	8.00
VISITING SERVICES				
9.00	Physician Services	0	0	9.00
10.00	Nursing Care	0	18,951	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	14,836	12.00
13.00	Occupational Therapy	0	0	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	0	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	714	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		8,052	39.00
40.00	Unit Cost Multiplier		0.233385	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 15-1305

Period: From 10/01/2014

Worksheet K-5

Hospice CCN: 15-1550

To 09/30/2015

Part I
Date/Time Prepared:
6/19/2017 1:30 pm

Cost Center Description		Hospice I			Subtotal	ADMINISTRATIVE & GENERAL	
		Hospice Trial Balance (1)	CAPITAL RELATED COSTS				
			NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT			
0	1.00	4.00	4A	5.00			
1.00	Administrative and General		3,281	13,800	17,081	2,983	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	23,374	0	0	23,374	4,082	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	18,298	0	0	18,298	3,195	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	881	0	0	881	154	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	42,553	3,281	13,800	59,634	10,414	34.00
35.00	Unit Cost Multiplier (see instructions)				0		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		Provider CCN: 15-1305	Period: From 10/01/2014	Worksheet K-5 Part I Date/Time Prepared: 6/19/2017 1:30 pm
		Hospice CCN: 15-1550	To 09/30/2015	

Cost Center Description	Hospice I					
	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
	7.00	8.00	9.00	10.00	13.00	
1.00 Administrative and General	3,668	0	1,101	0	0	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	3,668	0	1,101	0	0	34.00
35.00 Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		Provider CCN: 15-1305	Period: From 10/01/2014	Worksheet K-5
		Hospice CCN: 15-1550	To 09/30/2015	Part I
				Date/Time Prepared: 6/19/2017 1:30 pm

Cost Center Description		Hospice I				Subtotal (col s. 4A-23)	
		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
		14.00	15.00	16.00	17.00	24.00	
1.00	Administrative and General	0	0	309	887	26,029	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	27,456	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	21,493	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	1,035	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	309	887	76,013	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		Provider CCN: 15-1305 Hospice CCN: 15-1550	Period: From 10/01/2014 To 09/30/2015	Worksheet K-5 Part I Date/Time Prepared: 6/19/2017 1:30 pm
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Cost Center Description	Hospice I					
	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (col.s. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (col.s. 26 ± 27)		
	25.00	26.00	27.00	28.00		
1.00 Administrative and General						1.00
2.00 Inpatient - General Care	0	0	0	0		2.00
3.00 Inpatient - Respite Care	0	0	0	0		3.00
4.00 Physician Services	0	0	0	0		4.00
5.00 Nursing Care	0	27,456	14,298	41,754		5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00 Physical Therapy	0	21,493	11,192	32,685		7.00
8.00 Occupational Therapy	0	0	0	0		8.00
9.00 Speech/ Language Pathology	0	0	0	0		9.00
10.00 Medical Social Services	0	0	0	0		10.00
11.00 Spiritual Counseling	0	0	0	0		11.00
12.00 Dietary Counseling	0	0	0	0		12.00
13.00 Counseling - Other	0	0	0	0		13.00
14.00 Home Health Aide and Homemaker	0	1,035	539	1,574		14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00 Other	0	0	0	0		16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00 Analgesics	0	0	0	0		18.00
19.00 Sedatives / Hypnotics	0	0	0	0		19.00
20.00 Other - Specify	0	0	0	0		20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00 Patient Transportation	0	0	0	0		22.00
23.00 Imaging Services	0	0	0	0		23.00
24.00 Labs and Diagnostics	0	0	0	0		24.00
25.00 Medical Supplies	0	0	0	0		25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00 Radiation Therapy	0	0	0	0		27.00
28.00 Chemotherapy	0	0	0	0		28.00
29.00 Other	0	0	0	0		29.00
30.00 Bereavement Program Costs	0	0	0	0		30.00
31.00 Volunteer Program Costs	0	0	0	0		31.00
32.00 Fundraising	0	0	0	0		32.00
33.00 Other Program Costs	0	0	0	0		33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	76,013		76,013		34.00
35.00 Unit Cost Multiplier (see instructions)			0.520747			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 15-1305
Hospice CCN: 15-1550

Period:
From 10/01/2014
To 09/30/2015

Worksheet K-5
Part II
Date/Time Prepared:
6/19/2017 1:30 pm

Cost Center Description	Hospice I						
	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)	1.00					4.00
1.00 Administrative and General	191		39,713	0	17,081	191	1.00
2.00 Inpatient - General Care	0		0	0	0	0	2.00
3.00 Inpatient - Respite Care	0		0	0	0	0	3.00
4.00 Physician Services	0		0	0	0	0	4.00
5.00 Nursing Care	0		0	0	23,374	0	5.00
6.00 Nursing Care-Continuous Home Care	0		0	0	0	0	6.00
7.00 Physical Therapy	0		0	0	18,298	0	7.00
8.00 Occupational Therapy	0		0	0	0	0	8.00
9.00 Speech/ Language Pathology	0		0	0	0	0	9.00
10.00 Medical Social Services	0		0	0	0	0	10.00
11.00 Spiritual Counseling	0		0	0	0	0	11.00
12.00 Dietary Counseling	0		0	0	0	0	12.00
13.00 Counseling - Other	0		0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0		0	0	881	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0		0	0	0	0	15.00
16.00 Other	0		0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0		0	0	0	0	17.00
18.00 Analgesics	0		0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0		0	0	0	0	19.00
20.00 Other - Specify	0		0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0		0	0	0	0	21.00
22.00 Patient Transportation	0		0	0	0	0	22.00
23.00 Imaging Services	0		0	0	0	0	23.00
24.00 Labs and Diagnostics	0		0	0	0	0	24.00
25.00 Medical Supplies	0		0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0		0	0	0	0	26.00
27.00 Radiation Therapy	0		0	0	0	0	27.00
28.00 Chemotherapy	0		0	0	0	0	28.00
29.00 Other	0		0	0	0	0	29.00
30.00 Bereavement Program Costs	0		0	0	0	0	30.00
31.00 Volunteer Program Costs	0		0	0	0	0	31.00
32.00 Fundraising	0		0	0	0	0	32.00
33.00 Other Program Costs	0		0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	191		39,713		59,634	191	34.00
35.00 Total cost to be allocated	3,281		13,800		10,414	3,668	35.00
36.00 Unit Cost Multiplier (see instructions)	17.178010		0.347493		0.174632	19.204188	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 15-1305
Hospice CCN: 15-1550

Period:
From 10/01/2014
To 09/30/2015

Worksheet K-5
Part II
Date/Time Prepared:
6/19/2017 1:30 pm

Cost Center Description		Hospice I					
		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATIVE (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	
		8.00	9.00	10.00	13.00	14.00	
1.00	Administrative and General	0	191	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	191	0	0	0	34.00
35.00	Total cost to be allocated	0	1,101	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	5.764398	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 15-1305
Hospice CCN: 15-1550

Period:
From 10/01/2014
To 09/30/2015

Worksheet K-5
Part II
Date/Time Prepared:
6/19/2017 1:30 pm

Cost Center Description		Hospice I			
		PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (ALLOCATION OF TIME)	
		15.00	16.00	17.00	
1.00	Administrative and General	0	32,305	113	1.00
2.00	Inpatient - General Care	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	3.00
4.00	Physician Services	0	0	0	4.00
5.00	Nursing Care	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	6.00
7.00	Physical Therapy	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	9.00
10.00	Medical Social Services	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	12.00
13.00	Counseling - Other	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	15.00
16.00	Other	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	17.00
18.00	Analgesics	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	19.00
20.00	Other - Specify	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	21.00
22.00	Patient Transportation	0	0	0	22.00
23.00	Imaging Services	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	24.00
25.00	Medical Supplies	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	27.00
28.00	Chemotherapy	0	0	0	28.00
29.00	Other	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	31.00
32.00	Fundraising	0	0	0	32.00
33.00	Other Program Costs	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	32,305	113	34.00
35.00	Total cost to be allocated	0	309	887	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.009565	7.849558	36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 15-1305 Hospice CCN: 15-1550		Period: From 10/01/2014 To 09/30/2015		Worksheet K-5 Part III Date/Time Prepared: 6/19/2017 1:30 pm	
Cost Center Description		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)		
		0	1.00	2.00	3.00		
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.471569	0	0	1.00	
2.00	OCCUPATIONAL THERAPY	67.00	0.414971	0	0	2.00	
3.00	SPEECH PATHOLOGY	68.00	0.890002	0	0	3.00	
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.257139	0	0	4.00	
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00	
6.00	LABORATORY	60.00	0.175196	0	0	6.00	
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	6.01	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.254919	0	0	7.00	
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00	
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00	
10.00	ONCOLOGY	76.00	1.126280	0	0	10.00	
10.01	CARDIAC REHABILITATION	76.01				10.01	
11.00	Totals (sum of lines 1-10)				0	11.00	

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 15-1305
 Hospice CCN: 15-1550

Period:
 From 10/01/2014
 To 09/30/2015

Worksheet K-6
 Date/Time Prepared:
 6/19/2017 1:30 pm

		Hospice I			Total	
		Title XVIII	Title XIX	Other	4.00	
		1.00	2.00	3.00		
1.00	Total cost (see instructions)				76,013	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				129	2.00
3.00	Average cost per diem (line 1 divided by line 2)				589.25	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	102				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	60,104				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		8			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		4,714			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	27				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	15,910				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		8			10.00
11.00	Aggregate NF cost (line 3 times line 10)		4,714			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			19		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			11,196		13.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305

Period: From 10/01/2014

Worksheet M-1

Component CCN: 15-8512

To 09/30/2015

Date/Time Prepared: 6/19/2017 1:30 pm

		RHC I		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified	
					Cost	Trial Balance	
		1.00	2.00	3.00	4.00	(col. 3 + col. 4)	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	1,712,471	25,786	1,738,257	0	1,738,257	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	212,864	0	212,864	0	212,864	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	96,332	0	96,332	0	96,332	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	390,189	0	390,189	0	390,189	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,411,856	25,786	2,437,642	0	2,437,642	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	25,810	25,810	0	25,810	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	25,810	25,810	0	25,810	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,411,856	51,596	2,463,452	0	2,463,452	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
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
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
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	68,135	68,135	0	68,135	29.00
30.00	Administrative Costs	624,901	177,981	802,882	0	802,882	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	624,901	246,116	871,017	0	871,017	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,036,757	297,712	3,334,469	0	3,334,469	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-1305	Period:	Worksheet M-1
	Component CCN: 15-8512	From 10/01/2014 To 09/30/2015	Date/Time Prepared: 6/19/2017 1:30 pm
		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	1,738,257
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	212,864
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	96,332
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	390,189
10.00	Subtotal (sum of lines 1 through 9)	0	2,437,642
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0
15.00	Medical Supplies	0	25,810
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	25,810
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,463,452
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
25.01	Telehealth	0	0
25.02	Chronic Care Management	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	68,135
30.00	Administrative Costs	0	802,882
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	871,017
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	3,334,469

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2014 To 09/30/2015	Worksheet M-2 Date/Time Prepared: 6/19/2017 1:30 pm
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		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	4.91	14,738	4,200	20,622	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.68	4,111	2,100	3,528	3.00
4.00	Subtotal (sum of lines 1 through 3)	6.59	18,849		24,150	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)	6.59	18,849		24,150	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				2,463,452	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)				2,463,452	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet, M-1, col. 7, line 31)				871,017	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				2,222,794	15.00
16.00	Total overhead (sum of lines 14 and 15)				3,093,811	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				3,093,811	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				3,093,811	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				5,557,263	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2014 To 09/30/2015	Worksheet M-3 Date/Time Prepared: 6/19/2017 1:30 pm	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			5,557,263	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			61,959	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			5,495,304	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			24,150	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)			24,150	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			227.55	7.00
		Calculation of Limit (1)			
		Prior to January 1		On or 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)		79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)		227.55	227.55	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		836	2,789	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		190,232	634,637	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) *			824,869	16.00
16.01	Total program charges (see instructions)(from contractor's records)			432,680	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			5,243	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			9,996	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.)			634,289	16.04
16.05	Total program cost (see instructions)			644,285	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			22,012	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			81,085	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			644,285	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			17,744	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			662,029	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)			662,029	26.00
26.01	Sequestration adjustment (see instructions)			13,241	26.01
27.00	Interim payments			163,853	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)			484,935	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2014 To 09/30/2015	Worksheet M-4 Date/Time Prepared: 6/19/2017 1:30 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		2,437,642	2,437,642	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000637	0.001929	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,553	4,702	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		12,965	8,246	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		14,518	12,948	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,463,452	2,463,452	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		3,093,811	3,093,811	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.005893	0.005256	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		18,232	16,261	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		32,750	29,209	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		178	539	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		183.99	54.19	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		34	212	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		6,256	11,488	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			61,959	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			17,744	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2014 To 09/30/2015	Worksheet M-5 Date/Time Prepared: 6/19/2017 1:30 pm
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		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		163,853	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)		163,853	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		484,935	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		648,788	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00