

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: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/22/2017 4:01 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 5/22/2017	Time: 4:01 pm
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for Full or "L" for Low.		
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 KING'S DAUGHTERS' HOSPITAL (15-0069) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(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	-261,797	-3,454	-49,632	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	-1		0	9.00
200.00 Total	0	-261,797	-3,455	-49,632	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0069		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/22/2017 11:00 am						
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box: 447 State: IN Zip Code: 47250- County: JEFFERSON		3.00		4.00						
1.00 Street: ONE KINGS DAUGHTERS DRIVE		2.00 City: MADISON										
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				
3.00 Hospital and Hospital-Based Component Identification:												
3.00	Hospital	KING'S DAUGHTERS' HOSPITAL	150069	99915	1	06/17/1966	N	P	O	3.00		
4.00	Subprovider - IPF									4.00		
5.00	Subprovider - IRF									5.00		
6.00	Subprovider - (Other)									6.00		
7.00	Swing Beds - SNF									7.00		
8.00	Swing Beds - NF									8.00		
9.00	Hospital-Based SNF									9.00		
10.00	Hospital-Based NF									10.00		
11.00	Hospital-Based OLTC									11.00		
12.00	Hospital-Based HHA	KING'S DAUGHTERS' HOSPITAL HHA	157141	99915		03/08/1985	N	P	N	12.00		
13.00	Separately Certified ASC									13.00		
14.00	Hospital-Based Hospice	KING'S DAUGHTERS'	151535	99915		09/01/1995				14.00		
15.00	Hospital-Based Health Clinic - RHC									15.00		
16.00	Hospital-Based Health Clinic - FQHC									16.00		
17.00	Hospital-Based (CMHC) I									17.00		
18.00	Renal Dialysis									18.00		
19.00	Other									19.00		
						From:	To:					
						1.00	2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2016	12/31/2016		20.00			
21.00	Type of Control (see instructions)					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.					Y	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)					Y	Y		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.						3		N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days					
		1.00	2.00	3.00	4.00	5.00	6.00					
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.					366	576	17	13	2,122	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.					0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/22/2017 11:00 am		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		1			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.	01/01/2016	12/31/2016			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	XVII	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)		Y			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
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05

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	Y/N	IME	Direct GME	IME	Direct GME					
	1.00	2.00	3.00	4.00	5.00					
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						0.00	0.00	61.06	
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count					
	1.00	2.00	3.00	4.00						
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.						0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.						0.00	0.00	61.20	
						1.00				
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)										
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)						0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings										
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)						N	63.00		
	Program Name		Program Code	Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ col. 1 + col. 2))				
	1.00	2.00	3.00	4.00	5.00					
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
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

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		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
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
					1.00	
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N		87.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V		XIX									
		1.00		2.00									
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00							
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00							
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00							
Rural Providers													
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N				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. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N				107.00							
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00							
		Physical		Occupational		Speech		Respiratory					
		1.00		2.00		3.00		4.00					
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N		N		N		N		109.00			
								1.00					
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.					N				110.00			
								1.00		2.00		3.00	
Miscellaneous Cost Reporting Information													
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0				115.00			
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N								116.00			
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N								117.00			
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0								118.00			
		Premiums		Losses		Insurance							
		1.00		2.00		3.00							
118.01	List amounts of malpractice premiums and paid losses:	970,339		0		0				118.01			
								1.00		2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N								118.02			
119.00	DO NOT USE THIS LINE									119.00			
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	Y		Y						120.00			
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y								121.00			
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N								122.00			
Transplant Center Information													
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N								125.00			
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.									126.00			
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.									127.00			
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.									128.00			
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.									129.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.									130.00			
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.									131.00			
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.									132.00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/22/2017 11:00 am		
		1.00	2.00			
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00
		1.00	2.00	3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00
142.00	Street:	PO Box:				142.00
143.00	City:	State:		Zip Code:		143.00
						1.00
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00
						1.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		N		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00
						1.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00
		Part A		Part B		Title V
		1.00		2.00		3.00
						Title XIX
						4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
						1.00
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
		0		1.00		2.00
						Zip Code
						3.00
						CBSA
						4.00
						FTE/Campus
						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
						1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0
168.01	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)			0.25		169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/22/2017 11:00 am
		Beginning 1.00	Ending 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. 1, 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		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0069		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part II Date/Time Prepared: 5/22/2017 11:00 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		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)	N		N			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)	Y	03/13/2017	Y	03/13/2017		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: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/22/2017 11:00 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				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.				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?				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.	LUCIA		GERBER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502.992.3524		LGERBER@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/22/2017 11:00 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 15-0069

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

Worksheet S-3
Part I
Date/Time Prepared:
5/22/2017 11:00 am

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	
					Ti tle 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	83	30,378	0.00	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)		83	30,378	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,196	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					0	13.00
14.00 Total (see instructions)	43.00	89	32,574	0.00	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						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		89				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: 15-0069

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

Worksheet S-3
Part I
Date/Time Prepared:
5/22/2017 11:00 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,548	1,688	10,470			1.00
2.00 HMO and other (see instructions)	511	814				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	5,548	1,688	10,470			7.00
8.00 INTENSIVE CARE UNIT	773	162	1,289			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		332	1,135			13.00
14.00 Total (see instructions)	6,321	2,182	12,894	0.00	821.91	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	5,683	833	9,213	0.00	16.14	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	1.33	24.00
24.10 HOSPICE (non-distinct part)	2,722	10	3,003			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	839.38	27.00
28.00 Observation Bed Days		697	3,233			28.00
29.00 Ambulance Trips	1,823					29.00
30.00 Employee discount days (see instruction)			193			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	98	165			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: 15-0069

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

Worksheet S-3
Part I
Date/Time Prepared:
5/22/2017 11:00 am

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	1,542	552	3,228	1.00
2.00 HMO and other (see instructions)				131	0		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		1,542	552	3,228	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							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

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0069

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

Worksheet S-3
Part II
Date/Time Prepared:
5/22/2017 11:00 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	50,836,685	1,983	50,838,668	1,745,710.53	29.12
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	542,698	542,698	6,488.00	83.65
4.00	Physician-Part A - Administrative		10,071	0	10,071	105.00	95.91
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		2,605,587	0	2,605,587	11,284.00	230.91
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		21,598,539	-319,818	21,278,721	520,616.91	40.87
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		1,022,463	0	1,022,463	8,384.00	121.95
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		150,000	0	150,000	722.00	207.76
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,720,209	0	8,720,209		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		3,154,241	0	3,154,241		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		76,525	0	76,525		
22.00	Physician Part A - Administrative		1,307	0	1,307		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		221,063	0	221,063		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related		0	0	0		
25.51	Related orgainzation wage-related		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0069

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

Worksheet S-3
Part II
Date/Time Prepared:
5/22/2017 11:00 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
								1.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	29,786	0	29,786	1,960.80	15.19	26.00
27.00	Administrative & General	5.00	5,832,948	506,289	6,339,237	294,111.03	21.55	27.00
28.00	Administrative & General under contract (see inst.)		672,236	0	672,236	1,972.87	340.74	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	637,202	0	637,202	30,205.34	21.10	30.00
31.00	Laundry & Linen Service	8.00	42,182	0	42,182	4,387.70	9.61	31.00
32.00	Housekeeping	9.00	657,614	0	657,614	61,619.62	10.67	32.00
33.00	Housekeeping under contract (see instructions)		192,624	0	192,624	9,232.38	20.86	33.00
34.00	Dietary	10.00	684,582	-373,483	311,099	23,168.33	13.43	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	373,483	373,483	27,814.00	13.43	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	284,194	0	284,194	8,472.70	33.54	38.00
39.00	Central Services and Supply	14.00	78,171	0	78,171	5,935.68	13.17	39.00
40.00	Pharmacy	15.00	811,431	0	811,431	23,317.89	34.80	40.00
41.00	Medical Records & Medical Records Library	16.00	507,896	0	507,896	25,991.42	19.54	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0069

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

Worksheet S-3
Part III
Date/Time Prepared:
5/22/2017 11:00 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Pai d Hours Related to Sal ari es i n col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	49,095,958	-540,715	48,555,243	1,739,143.78	27.92	1.00
2.00	Excluded area salaries (see instructions)	21,598,539	-319,818	21,278,721	520,616.91	40.87	2.00
3.00	Subtotal salaries (line 1 minus line 2)	27,497,419	-220,897	27,276,522	1,218,526.87	22.38	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,172,463	0	1,172,463	9,106.00	128.76	4.00
5.00	Subtotal wage-related costs (see inst.)	8,721,516	0	8,721,516	0.00	31.97	5.00
6.00	Total (sum of lines 3 thru 5)	37,391,398	-220,897	37,170,501	1,227,632.87	30.28	6.00
7.00	Total overhead cost (see instructions)	10,430,866	506,289	10,937,155	518,189.76	21.11	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part IV Date/Time Prepared: 5/22/2017 11:00 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,661,657	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	6,809,034	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	78,483	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	140,323	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	214,582	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	3,246,713	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	22,553	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,173,345	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part V Date/Time Prepared: 5/22/2017 11:00 am
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,022,463	12,173,345	1.00
2.00	Hospital	1,022,463	8,698,274	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	3,475,071	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 15-0069 Component CCN: 15-7141			Period: From 01/01/2016 To 12/31/2016		Worksheet S-4 Date/Time Prepared: 5/22/2017 11:00 am	
					Home Health Agency I		PPS	
					1.00			
0.00	County						0.00	
		Title V	Title XVIII	Title XIX	Other	Total		
		1.00	2.00	3.00	4.00	5.00		
HOME HEALTH AGENCY STATISTICAL DATA								
1.00	Home Health Aide Hours	0	0	0	0	0	1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	325.00	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)	0.00			0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)				0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel				0.00	0.00	0.00	5.00
6.00	Direct Nursing Service				0.00	0.00	0.00	6.00
7.00	Nursing Supervisor				0.00	0.00	0.00	7.00
8.00	Physical Therapy Service				0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor				0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service				0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor				0.00	0.00	0.00	11.00
12.00	Speech Pathology Service				0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor				0.00	0.00	0.00	13.00
14.00	Medical Social Service				0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor				0.00	0.00	0.00	15.00
16.00	Home Health Aide				0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor				0.00	0.00	0.00	17.00
18.00	Other (specify)				0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES								
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).				50031			20.00
20.01					50034			20.01
		Full Episodes			LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA								
21.00	Skilled Nursing Visits	2,252	288	53	26	2,619	21.00	
22.00	Skilled Nursing Visit Charges	512,861	65,664	12,069	5,928	596,522	22.00	
23.00	Physical Therapy Visits	1,766	71	25	57	1,919	23.00	
24.00	Physical Therapy Visit Charges	359,952	14,484	5,100	11,620	391,156	24.00	
25.00	Occupational Therapy Visits	434	23	7	11	475	25.00	
26.00	Occupational Therapy Visit Charges	97,974	5,198	1,582	2,486	107,240	26.00	
27.00	Speech Pathology Visits	8	0	1	2	11	27.00	
28.00	Speech Pathology Visit Charges	1,864	0	233	466	2,563	28.00	
29.00	Medical Social Service Visits	1	0	0	0	1	29.00	
30.00	Medical Social Service Visit Charges	308	0	0	0	308	30.00	
31.00	Home Health Aide Visits	578	62	5	13	658	31.00	
32.00	Home Health Aide Visit Charges	77,386	8,308	670	1,742	88,106	32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,039	444	91	109	5,683	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)	1,050,345	93,654	19,654	22,242	1,185,895	35.00	
36.00	Total Number of Episodes (standard/non outlier)	299		33	11	343	36.00	
37.00	Total Number of Outlier Episodes		10		0	10	37.00	
38.00	Total Non-Routine Medical Supply Charges	135,257	20,191	3,554	263	159,265	38.00	

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA		Provider CCN: 15-0069 Hospice CCN: 15-1535	Period: From 01/01/2016 To 12/31/2016	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 5/22/2017 11:00 am
		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							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							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	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	1,887	5	195	2,087	11.00
12.00	Hospice Inpatient Respite Care	0	0	0	0	12.00
13.00	Hospice General Inpatient Care	7	5	8	20	13.00
14.00	Total Hospice Days	1,894	10	203	2,107	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet S-10 Date/Time Prepared: 5/22/2017 11:00 am
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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)		0.252402	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		5,742,914	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		46,358,567	6.00	
7.00	Medicaid cost (line 1 times line 6)		11,700,995	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)		5,958,081	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)		5,958,081	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)		
20.00	Charity care charges for the entire facility (see instructions)	843,491	187,895	1,031,386	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	212,899	47,425	260,324	21.00
22.00	Partial payment by patients approved for charity care	106,990	0	106,990	22.00
23.00	Cost of charity care (line 21 minus line 22)	105,909	47,425	153,334	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		14,311,404	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		356,167	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		13,955,237	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		3,522,330	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		3,675,664	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		9,633,745	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0069

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

Worksheet A
Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		17,874,304	17,874,304	221,189	18,095,493	1.00
1.01	00101			0	28,667	28,667	1.01
2.00	00200			0	0	0	2.00
3.00	00300			0	0	0	3.00
4.00	00400	29,786	13,245,166	13,274,952	-78,508	13,196,444	4.00
5.00	00500	5,832,948	12,236,185	18,069,133	-866,233	17,202,900	5.00
7.00	00700	637,202	2,305,109	2,942,311	0	2,942,311	7.00
8.00	00800	42,182	283,330	325,512	0	325,512	8.00
9.00	00900	657,614	444,348	1,101,962	0	1,101,962	9.00
10.00	01000	684,582	426,575	1,111,157	-606,207	504,950	10.00
11.00	01100	0	0	0	606,207	606,207	11.00
13.00	01300	284,194	896	285,090	0	285,090	13.00
14.00	01400	78,171	328,639	406,810	0	406,810	14.00
15.00	01500	811,431	5,249,815	6,061,246	0	6,061,246	15.00
16.00	01600	507,896	250,591	758,487	0	758,487	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	619,223	619,223	19.00
23.00	02300	104,666	9,013	113,679	0	113,679	23.00
23.01	02301	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,985,583	229,289	5,214,872	-711,993	4,502,879	30.00
31.00	03100	919,320	6,515	925,835	0	925,835	31.00
43.00	04300	0	0	0	294,446	294,446	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,695,093	746,579	2,441,672	0	2,441,672	50.00
51.00	05100	263,599	1,634	265,233	0	265,233	51.00
52.00	05200	0	0	0	417,547	417,547	52.00
53.00	05300	1,286,034	605,142	1,891,176	-542,698	1,348,478	53.00
54.00	05400	2,524,498	823,065	3,347,563	-10,976	3,336,587	54.00
54.01	03630	112,090	55,094	167,184	0	167,184	54.01
54.02	03450	73,917	197,549	271,466	0	271,466	54.02
55.00	03480	1,138,556	794,717	1,933,273	0	1,933,273	55.00
57.00	05700	203,432	257,015	460,447	0	460,447	57.00
58.00	05800	132,446	137,971	270,417	0	270,417	58.00
59.00	05900	200,972	4,447	205,419	0	205,419	59.00
60.00	06000	1,552,525	2,900,671	4,453,196	-173,512	4,279,684	60.00
62.00	06200	0	251,614	251,614	0	251,614	62.00
65.00	06500	590,449	51,868	642,317	0	642,317	65.00
66.00	06600	1,740,746	44,033	1,784,779	0	1,784,779	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	0	0	69.00
69.01	03610	132,415	66,654	199,069	0	199,069	69.01
71.00	07100	0	3,300,393	3,300,393	0	3,300,393	71.00
71.01	07101	0	99,017	99,017	0	99,017	71.01
72.00	07200	0	4,265,082	4,265,082	0	4,265,082	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03140	422,532	90,282	512,814	0	512,814	76.00
76.97	07697	71,656	8,417	80,073	0	80,073	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	132,557	594	133,151	0	133,151	90.00
91.00	09100	1,493,720	393,272	1,886,992	0	1,886,992	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	1,456,917	177,759	1,634,676	0	1,634,676	95.00
101.00	10100	889,760	87,051	976,811	197	977,008	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		0	0	0	0	113.00
116.00	11600	68,442	102,573	171,015	-197	170,818	116.00
118.00		31,757,931	68,352,268	100,110,199	-802,848	99,307,351	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	98,164	98,164	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	1,550,700	340,197	1,890,897	0	1,890,897	194.01
194.02	07952	5,280,099	1,309,847	6,589,946	123,294	6,713,240	194.02
194.03	07953	641,268	20,254	661,522	1,037,721	1,699,243	194.03
194.04	07954	217,649	39,668	257,317	0	257,317	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	4,264,092	307,208	4,571,300	-123,916	4,447,384	194.06
194.07	07957	3,570,734	272,868	3,843,602	-200,000	3,643,602	194.07
194.08	07958	1,092,600	137,325	1,229,925	0	1,229,925	194.08

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 15-0069		Period: From 01/01/2016 To 12/31/2016		Worksheet A Date/Time Prepared: 5/22/2017 11:00 am	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.09	07959	KDH - MC ENT	570,366	13,374	583,740	-116,718	467,022	194.09
194.10	07960	KDH - MC UROLOGY	89,339	593,130	682,469	0	682,469	194.10
194.11	07961	KDH - MC OB/GYN	1,801,907	468,944	2,270,851	-15,697	2,255,154	194.11
200.00		TOTAL (SUM OF LINES 118-199)	50,836,685	71,855,083	122,691,768	0	122,691,768	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0069

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

Worksheet A
Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-2,002,783	16,092,710	1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	28,667	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,478,857	10,717,587	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,219,540	13,983,360	5.00
7.00	00700	OPERATION OF PLANT	-26,038	2,916,273	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	325,512	8.00
9.00	00900	HOUSEKEEPING	0	1,101,962	9.00
10.00	01000	DIETARY	0	504,950	10.00
11.00	01100	CAFETERIA	-318,793	287,414	11.00
13.00	01300	NURSING ADMINISTRATION	-117,540	167,550	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	406,810	14.00
15.00	01500	PHARMACY	-35,195	6,026,051	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-759	757,728	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-619,223	0	19.00
23.00	02300	RADIOLOGY SCHOOL	-45,325	68,354	23.00
23.01	02301	HUB SITE - 3RD YEAR MED STUDENTS	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	170	4,503,049	30.00
31.00	03100	INTENSIVE CARE UNIT	0	925,835	31.00
43.00	04300	NURSERY	0	294,446	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-280,086	2,161,586	50.00
51.00	05100	RECOVERY ROOM	0	265,233	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	417,547	52.00
53.00	05300	ANESTHESIOLOGY	-1,286,149	62,329	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,693,518	1,643,069	54.00
54.01	03630	ULTRA SOUND	0	167,184	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	271,466	54.02
55.00	03480	ONCOLOGY	-797,684	1,135,589	55.00
57.00	05700	CT SCAN	0	460,447	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	270,417	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	205,419	59.00
60.00	06000	LABORATORY	-61,868	4,217,816	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	251,614	62.00
65.00	06500	RESPIRATORY THERAPY	0	642,317	65.00
66.00	06600	PHYSICAL THERAPY	-2,605	1,782,174	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	03610	SLEEP LAB	-1,072	197,997	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,300,393	71.00
71.01	07101	IV SOLUTIONS	0	99,017	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,265,082	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03140	CARDIOLOGY	-612	512,202	76.00
76.97	07697	CARDIAC REHABILITATION	0	80,073	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	133,151	90.00
91.00	09100	EMERGENCY	-363,075	1,523,917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-63	1,634,613	95.00
101.00	10100	HOME HEALTH AGENCY	0	977,008	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	170,818	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-13,350,615	85,956,736	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	98,164	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	194.00
194.01	07951	MOB	0	1,890,897	194.01
194.02	07952	PHYSICIAN CLINICS	0	6,713,240	194.02
194.03	07953	PHYS PRAC BUS OFC	0	1,699,243	194.03
194.04	07954	MOB - MAIN CAMPUS	0	257,317	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	4,447,384	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	3,643,602	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	1,229,925	194.08
194.09	07959	KDH - MC ENT	0	467,022	194.09

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0069		Period: From 01/01/2016 To 12/31/2016	Worksheet A Date/Time Prepared: 5/22/2017 11:00 am
Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
194.10 07960	KDH - MC UROLOGY	0	682,469		194.10
194.11 07961	KDH - MC OB/GYN	0	2,255,154		194.11
200.00	TOTAL (SUM OF LINES 118-199)	-13,350,615	109,341,153		200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00	3.00	4.00	5.00		
A - CAFETERIA					
1.00	CAFETERIA	11.00	373,483	232,724	1.00
	O		373,483	232,724	
D - RADIOLOGY DIRECTOR					
1.00	PHYSICIAN CLINICS	194.02	10,976	0	1.00
	O		10,976	0	
E - DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	1.01	0	28,667	1.00
	O		0	28,667	
F - NURSERY- L&D					
1.00	NURSERY	43.00	290,169	4,277	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	411,482	6,065	2.00
	O		701,651	10,342	
H - GIFT SHOP					
1.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00	0	98,164	1.00
	O		0	98,164	
K - CRNA EXPENSE					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	542,698	76,525	1.00
2.00	O	0.00	0	0	2.00
	O		542,698	76,525	
M - PHYSICIAN BILLING AND COLLECTIONS					
1.00	PHYS PRAC BUS OFC	194.03	0	1,024,502	1.00
	TOTALS		0	1,024,502	
N - INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	249,856	1.00
	O		0	249,856	
O - HHA MSW SALARIES					
1.00	HOME HEALTH AGENCY	101.00	197	0	1.00
	O		197	0	
P - EMPLOYEE BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	517,525	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		517,525	0	
Q - LAB PHYSICIAN CLINICS					
1.00	PHYSICIAN CLINICS	194.02	173,512	0	1.00
	TOTALS		173,512	0	
R - PHYSICIAN BILLING SPECIALIST					
1.00	PHYS PRAC BUS OFC	194.03	13,219	0	1.00
2.00	O	0.00	0	0	2.00
	TOTALS		13,219	0	
500.00	Grand Total: Increases		2,333,261	1,720,780	500.00

		Decreases				Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - CAFETERIA							
1.00	DIETARY	10.00	373,483	232,724	0		1.00
	O		373,483	232,724			
D - RADIOLOGY DIRECTOR							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	10,976	0	0		1.00
	O		10,976	0			
E - DEPRECIATION							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	28,667		9	1.00
	O		0	28,667			
F - NURSERY- L&D							
1.00	ADULTS & PEDIATRICS	30.00	701,651	10,342	0		1.00
2.00	O	0.00	0	0	0		2.00
	O		701,651	10,342			
H - GIFT SHOP							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	98,164	0		1.00
	O		0	98,164			
K - CRNA EXPENSE							
1.00	ANESTHESIOLOGY	53.00	542,698	0	0		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	76,525	0		2.00
	O		542,698	76,525			
M - PHYSICIAN BILLING AND COLLECTIONS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,024,502	0		1.00
	TOTALS		0	1,024,502			
N - INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	249,856		12	1.00
	O		0	249,856			
O - HHA MSW SALARIES							
1.00	HOSPICE	116.00	197	0	0		1.00
	O		197	0			
P - EMPLOYEE BENEFITS							
1.00	PHYSICIAN CLINICS	194.02	61,194	0	0		1.00
2.00	KDH - MC FAMILY PRACTICE	194.06	123,916	0	0		2.00
3.00	KDH - MC ORTHOPEDICS	194.07	200,000	0	0		3.00
4.00	KDH - MC ENT	194.09	116,718	0	0		4.00
5.00	KDH - MC OB/GYN	194.11	15,697	0	0		5.00
	TOTALS		517,525	0			
Q - LAB PHYSICIAN CLINICS							
1.00	LABORATORY	60.00	173,512	0	0		1.00
	TOTALS		173,512	0			
R - PHYSICIAN BILLING SPECIALIST							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,983	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	11,236	0	0		2.00
	TOTALS		11,236	1,983			
500.00	Grand Total: Decreases		2,331,278	1,722,763			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0069

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

Worksheet A-7
Part I
Date/Time Prepared:
5/22/2017 11:00 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	4,096,085	0	0	0	1.00
2.00	Land Improvements	841,699	0	0	0	2.00
3.00	Buildings and Fixtures	119,123,429	152,098	0	152,098	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	62,831,096	2,947,316	0	2,947,316	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	186,892,309	3,099,414	0	3,099,414	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	186,892,309	3,099,414	0	3,099,414	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	4,096,085	0			1.00
2.00	Land Improvements	841,699	0			2.00
3.00	Buildings and Fixtures	119,248,527	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	64,213,779	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	188,400,090	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	188,400,090	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0069

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

Worksheet A-7
Part II
Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	12,149,839	222,600	5,466,172	0	35,693	1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	12,149,839	222,600	5,466,172	0	35,693	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	17,874,304				1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	17,874,304				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0069

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

Worksheet A-7
Part III
Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	119,123,429	0	119,123,429	0.654688	0	1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	0	0.000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	62,831,096	0	62,831,096	0.345312	0	2.00
3.00	Total (sum of lines 1-2)	181,954,525	0	181,954,525	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	12,121,172	153,450	1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	0	28,667	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,149,839	153,450	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	3,739,373	249,856	35,693	-206,834	16,092,710	1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	0	0	28,667	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,739,373	249,856	35,693	-206,834	16,121,377	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.	
			1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-55,052	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01 Investment income - NEW CAP REL COSTS-BLDG & FIXT HHA/HO (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT HHA/HO	1.01		1.01
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP	2.00		2.00
3.00 Investment income - other (chapter 2)		0		0.00		3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00		4.00
5.00 Refunds and rebates of expenses (chapter 8)	A	-223,541	ADMINISTRATIVE & GENERAL	5.00		5.00
6.00 Rental of provider space by suppliers (chapter 8)	A	-69,150	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-3,822	OPERATION OF PLANT	7.00		7.00
8.00 Television and radio service (chapter 21)	A	-22,216	OPERATION OF PLANT	7.00		8.00
9.00 Parking lot (chapter 21)		0		0.00		9.00
10.00 Provider-based physician adjustment	A-8-2	-4,486,562				10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00		11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0				12.00
13.00 Laundry and linen service		0		0.00		13.00
14.00 Cafeteria-employees and guests	B	-318,793	CAFETERIA	11.00		14.00
15.00 Rental of quarters to employees and others		0		0.00		15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00		16.00
17.00 Sale of drugs to other than patients		0		0.00		17.00
18.00 Sale of medical records and abstracts	B	-759	MEDICAL RECORDS & LIBRARY	16.00		18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00		19.00
20.00 Vending machines		0		0.00		20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		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			NEW CAP REL COSTS-BLDG & FIXT	1.00		26.00
26.01 Depreciation - NEW CAP REL COSTS-BLDG & FIXT HHA/HO			NEW CAP REL COSTS-BLDG & FIXT HHA/HO	1.01		26.01
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2.00		27.00
28.00 Non-physician Anesthetist	A	-619,223	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant		0		0.00		29.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0069

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

Worksheet A-8

Date/Time Prepared:
5/22/2017 11:00 am

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	
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00	30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00
33.00 PATIENT PHONES - SALARY	A	-4,660		ADMINISTRATIVE & GENERAL	5.00	0 33.00
34.00		0			0.00	0 34.00
35.00 PHARMACY - SELF INSURANCE	B	-35,195		PHARMACY	15.00	0 35.00
36.00 DONATIONS EXPENSE	A	-113,084		ADMINISTRATIVE & GENERAL	5.00	0 36.00
37.00 ADVERTISING	A	-172,746		ADMINISTRATIVE & GENERAL	5.00	0 37.00
38.00 HOSPITAL ASSOCIATION DUES	A	-7,955		ADMINISTRATIVE & GENERAL	5.00	0 38.00
39.00 SELF INSURANCE	A	-2,478,857		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 39.00
40.00 PHYSICIAN RECRUITING	A	-359,761		ADMINISTRATIVE & GENERAL	5.00	0 40.00
41.00 UNNECESSARY BORROWING	A	-1,671,747		NEW CAP REL COSTS-BLDG & FIXT	1.00	11 41.00
42.00		0			0.00	0 42.00
43.00 HAF MEDICAID TAX OFFSET	A	-2,323,666		ADMINISTRATIVE & GENERAL	5.00	0 43.00
44.00		0			0.00	0 44.00
45.00 BAXTER PUMP REVENUE	B	-117,540		NURSING ADMINISTRATION	13.00	0 45.00
46.00 COPIER BUYOUT	B	-206,834		NEW CAP REL COSTS-BLDG & FIXT	1.00	14 46.00
47.00 RADIOLOGY SCHOOL TUITION	B	-45,325		RADIOLOGY SCHOOL	23.00	0 47.00
48.00 HUB SITE - 3RD YEAR MED STUDENTS	B	-14,127		ADMINISTRATIVE & GENERAL	5.00	0 48.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,350,615				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0069

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

Worksheet A-8-2

Date/Time Prepared:
5/22/2017 11:00 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	-170	-170	0	206,300	0	1.00
2.00	50.00	OPERATING ROOM	280,086	280,086	0	240,300	0	2.00
3.00	53.00	ANESTHESIOLOGY	542,813	542,813	0	542,813	0	3.00
4.00	53.00	ANESTHESIOLOGY	743,336	743,336	0	542,813	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	209,744	209,744	0	265,200	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	1,483,774	1,483,774	0	265,200	0	6.00
7.00	55.00	ONCOLOGY	52,859	52,859	0	265,200	0	7.00
8.00	55.00	ONCOLOGY	367,250	367,250	0	265,200	0	8.00
9.00	55.00	ONCOLOGY	377,575	377,575	0	265,200	0	9.00
10.00	60.00	LABORATORY	150,000	0	150,000	253,900	722	10.00
11.00	66.00	PHYSICAL THERAPY	2,605	2,605	0	206,300	0	11.00
12.00	69.01	SLEEP LAB	11,143	1,072	10,071	206,300	105	12.00
13.00	76.00	CARDIOLOGY	612	612	0	206,300	0	13.00
14.00	91.00	EMERGENCY	363,075	363,075	0	206,300	0	14.00
15.00	95.00	AMBULANCE SERVICES	360	0	360	206,300	3	15.00
200.00			4,585,062	4,424,631	160,431		830	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	55.00	ONCOLOGY	0	0	0	0	0	7.00
8.00	55.00	ONCOLOGY	0	0	0	0	0	8.00
9.00	55.00	ONCOLOGY	0	0	0	0	0	9.00
10.00	60.00	LABORATORY	88,132	4,407	0	0	0	10.00
11.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	11.00
12.00	69.01	SLEEP LAB	10,414	521	0	0	0	12.00
13.00	76.00	CARDIOLOGY	0	0	0	0	0	13.00
14.00	91.00	EMERGENCY	0	0	0	0	0	14.00
15.00	95.00	AMBULANCE SERVICES	297	15	0	0	0	15.00
200.00			98,843	4,943	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	-170		1.00
2.00	50.00	OPERATING ROOM	0	0	0	280,086		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	542,813		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	743,336		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	209,744		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,483,774		6.00
7.00	55.00	ONCOLOGY	0	0	0	52,859		7.00
8.00	55.00	ONCOLOGY	0	0	0	367,250		8.00
9.00	55.00	ONCOLOGY	0	0	0	377,575		9.00
10.00	60.00	LABORATORY	0	88,132	61,868	61,868		10.00
11.00	66.00	PHYSICAL THERAPY	0	0	0	2,605		11.00
12.00	69.01	SLEEP LAB	0	10,414	0	1,072		12.00
13.00	76.00	CARDIOLOGY	0	0	0	612		13.00
14.00	91.00	EMERGENCY	0	0	0	363,075		14.00
15.00	95.00	AMBULANCE SERVICES	0	297	63	63		15.00
200.00			0	98,843	61,931	4,486,562		200.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 5/22/2017 11:00 am
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP		
		0	1.00	1.01		
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	16,092,710	16,092,710			1.00
1.01 00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	28,667	0	28,667		1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	0			0	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	10,717,587	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	13,983,360	1,832,403	0	0	5.00
7.00 00700	OPERATION OF PLANT	2,916,273	2,161,966	0	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	325,512	80,459	0	0	8.00
9.00 00900	HOUSEKEEPING	1,101,962	141,035	0	0	9.00
10.00 01000	DIETARY	504,950	265,649	0	0	10.00
11.00 01100	CAFETERIA	287,414	107,433	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	167,550	94,305	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	406,810	130,693	0	0	14.00
15.00 01500	PHARMACY	6,026,051	97,133	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	757,728	247,202	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00 02300	RADIOLOGY SCHOOL	68,354	27,903	0	0	23.00
23.01 02301	HUB SITE - 3RD YEAR MED STUDENTS	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	4,503,049	1,680,181	0	0	30.00
31.00 03100	INTENSIVE CARE UNIT	925,835	70,665	0	0	31.00
43.00 04300	NURSERY	294,446	82,527	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,161,586	742,198	0	0	50.00
51.00 05100	RECOVERY ROOM	265,233	58,044	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	417,547	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	62,329	5,488	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,643,069	457,636	0	0	54.00
54.01 03630	ULTRA SOUND	167,184	0	0	0	54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	271,466	20,389	0	0	54.02
55.00 03480	ONCOLOGY	1,135,589	522,181	0	0	55.00
57.00 05700	CT SCAN	460,447	37,781	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	270,417	45,591	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	205,419	36,050	0	0	59.00
60.00 06000	LABORATORY	4,217,816	263,370	0	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	251,614	11,778	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	642,317	50,530	0	0	65.00
66.00 06600	PHYSICAL THERAPY	1,782,174	597,616	0	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 03610	SLEEP LAB	197,997	35,417	0	0	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,300,393	0	0	0	71.00
71.01 07101	IV SOLUTIONS	99,017	0	0	0	71.01
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	4,265,082	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03140	CARDIOLOGY	512,202	255,265	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	80,073	29,676	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	133,151	32,082	0	0	90.00
91.00 09100	EMERGENCY	1,523,917	585,881	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	1,634,613	199,754	0	0	95.00
101.00 10100	HOME HEALTH AGENCY	977,008	0	22,559	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	170,818	0	6,108	0	116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	85,956,736	11,006,281	28,667	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	98,164	0	0	0	190.00
194.00 07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01 07951	MOB	1,890,897	1,737,676	0	0	194.01
194.02 07952	PHYSICIAN CLINICS	6,713,240	1,485,661	0	0	194.02
194.03 07953	PHYS PRAC BUS OFC	1,699,243	41,749	0	0	194.03
194.04 07954	MOB - MAIN CAMPUS	257,317	1,821,343	0	0	194.04
194.05 07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	194.05
194.06 07956	KDH - MC FAMILY PRACTICE	4,447,384	0	0	0	194.06

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

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

Worksheet B
Part I
Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP		
		1.00	1.01	2.00		
194.07 07957 KDH - MC ORTHOPEDICS	3,643,602	0	0	0	751,757	194.07
194.08 07958 KDH - MC GENERAL SURGERY	1,229,925	0	0	0	230,028	194.08
194.09 07959 KDH - MC ENT	467,022	0	0	0	120,081	194.09
194.10 07960 KDH - MC UROLOGY	682,469	0	0	0	18,809	194.10
194.11 07961 KDH - MC OB/GYN	2,255,154	0	0	0	379,361	194.11
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)	109,341,153	16,092,710	28,667	0	10,717,587	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

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

Worksheet B
Part I
Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	17,134,233	17,134,233				5.00
7.00	00700	5,212,391	968,587	6,180,978			7.00
8.00	00800	414,852	77,089	40,716	532,657		8.00
9.00	00900	1,381,446	256,706	71,370	0	1,709,522	9.00
10.00	01000	836,096	155,367	134,430	0	0	10.00
11.00	01100	473,477	87,983	54,366	0	0	11.00
13.00	01300	321,687	59,777	47,722	0	0	13.00
14.00	01400	553,961	102,939	66,136	0	17,710	14.00
15.00	01500	6,294,017	1,169,579	49,154	0	23,269	15.00
16.00	01600	1,111,859	206,610	125,095	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	118,117	21,949	14,120	0	5,951	23.00
23.01	02301	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	7,091,263	1,317,727	850,243	191,424	832,615	30.00
31.00	03100	1,190,047	221,139	35,760	0	36,524	31.00
43.00	04300	435,462	80,919	41,762	0	7,269	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,307,841	614,676	375,583	105,949	113,849	50.00
51.00	05100	378,773	70,385	29,372	12,161	0	51.00
52.00	05200	500,654	93,034	0	0	21,665	52.00
53.00	05300	224,314	41,683	2,777	0	0	53.00
54.00	05400	2,630,060	488,728	231,583	33,093	64,212	54.00
54.01	03630	190,783	35,452	0	3,625	7,162	54.01
54.02	03450	307,417	57,125	10,318	2,227	4,312	54.02
55.00	03480	1,897,474	352,596	264,246	14,115	86,126	55.00
57.00	05700	541,057	100,541	19,119	15,677	6,984	57.00
58.00	05800	343,892	63,903	23,071	4,233	5,381	58.00
59.00	05900	283,780	52,733	18,243	0	14,610	59.00
60.00	06000	4,808,044	893,450	133,276	0	48,818	60.00
62.00	06200	263,392	48,945	5,960	0	0	62.00
65.00	06500	817,156	151,847	25,570	0	0	65.00
66.00	06600	2,746,274	510,324	302,419	35,490	18,173	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	0	0	69.00
69.01	03610	261,292	48,554	17,923	2,124	14,717	69.01
71.00	07100	3,300,393	613,292	0	0	0	71.00
71.01	07101	99,017	18,400	0	0	0	71.01
72.00	07200	4,265,082	792,555	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03140	856,424	159,144	129,175	16,540	18,102	76.00
76.97	07697	124,835	23,197	15,017	0	8,053	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	193,141	35,890	16,235	6	8,552	90.00
91.00	09100	2,424,275	450,488	296,481	76,024	138,615	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	2,141,096	397,867	101,084	11,846	0	95.00
101.00	10100	1,186,932	220,560	58,702	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	191,294	35,547	0	0	0	116.00
118.00		76,853,600	11,097,287	3,607,028	524,534	1,502,669	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	98,164	18,241	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	3,955,047	734,943	879,338	1,079	0	194.01
194.02	07952	9,310,536	1,730,100	751,808	2,422	0	194.02
194.03	07953	1,876,000	348,606	21,127	0	0	194.03
194.04	07954	2,124,482	394,780	921,677	0	206,853	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	5,345,116	993,251	0	223	0	194.06
194.07	07957	4,395,359	816,763	0	1,016	0	194.07
194.08	07958	1,459,953	271,294	0	1,205	0	194.08
194.09	07959	587,103	109,098	0	0	0	194.09
194.10	07960	701,278	130,314	0	0	0	194.10
194.11	07961	2,634,515	489,556	0	2,178	0	194.11

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

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

Worksheet B
Part I
Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
200.00	Cross Foot Adjustments	0					200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	109,341,153	17,134,233	6,180,978	532,657	1,709,522	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

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

Worksheet B
Part I
Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
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	1,125,893					10.00
11.00	01100	0	615,826				11.00
13.00	01300	0	5,901	435,087			13.00
14.00	01400	0	4,118	0	744,864		14.00
15.00	01500	0	16,174	0	4,848	7,557,041	15.00
16.00	01600	0	17,746	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	2,764	0	0	0	23.00
23.01	02301	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,040,707	130,913	209,089	204,393	0	30.00
31.00	03100	85,186	20,095	32,096	86	0	31.00
43.00	04300	0	7,132	11,391	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	53,013	84,672	314,590	0	50.00
51.00	05100	0	5,867	9,371	3,419	0	51.00
52.00	05200	0	10,113	16,153	0	0	52.00
53.00	05300	0	12,338	0	20,969	0	53.00
54.00	05400	0	52,539	0	4,760	0	54.00
54.01	03630	0	2,548	0	3,040	0	54.01
54.02	03450	0	1,979	0	14,678	0	54.02
55.00	03480	0	20,228	0	8,693	0	55.00
57.00	05700	0	5,835	0	3,232	0	57.00
58.00	05800	0	2,921	0	0	0	58.00
59.00	05900	0	4,828	0	1,793	0	59.00
60.00	06000	0	57,462	0	38,888	0	60.00
62.00	06200	0	0	0	0	0	62.00
65.00	06500	0	16,253	0	471	0	65.00
66.00	06600	0	42,246	0	1,785	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	0	0	69.00
69.01	03610	0	2,591	0	0	0	69.01
71.00	07100	0	0	0	0	0	71.00
71.01	07101	0	0	0	0	0	71.01
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	7,557,041	73.00
76.00	03140	0	13,122	0	2,159	0	76.00
76.97	07697	0	2,411	0	38	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	2,752	0	52	0	90.00
91.00	09100	0	45,276	72,315	41,735	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	56,446	0	3,603	0	95.00
101.00	10100	0	0	0	2,975	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
116.00	11600	0	0	0	0	0	116.00
118.00		1,125,893	615,611	435,087	676,207	7,557,041	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	290	0	190.00
194.00	07950	0	0	0	5,161	0	194.00
194.01	07951	0	0	0	27,619	0	194.01
194.02	07952	0	215	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	6,975	0	194.05
194.06	07956	0	0	0	7,906	0	194.06
194.07	07957	0	0	0	5,711	0	194.07
194.08	07958	0	0	0	3,118	0	194.08
194.09	07959	0	0	0	3,569	0	194.09
194.10	07960	0	0	0	8,308	0	194.10

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0069		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part I Date/Time Prepared: 5/22/2017 11:00 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
194.11	07961	KDH - MC OB/GYN	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,125,893	615,826	435,087	744,864	7,557,041	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 5/22/2017 11:00 am		
Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	RADIOLOGY SCHOOL	HUB SITE - 3RD YEAR MED STUDENTS
		16.00	17.00	19.00	23.00	23.01
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,461,310			16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
23.00	02300	RADIOLOGY SCHOOL	0	0	162,901	23.00
23.01	02301	HUB SITE - 3RD YEAR MED STUDENTS	0	0		23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	74,345	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	13,491	0	0	31.00
43.00	04300	NURSERY	7,489	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	150,221	0	0	50.00
51.00	05100	RECOVERY ROOM	30,814	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,619	0	0	52.00
53.00	05300	ANESTHESIOLOGY	30,219	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,870	0	0	54.00
54.01	03630	ULTRA SOUND	9,783	0	162,901	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	28,728	0	0	54.02
55.00	03480	ONCOLOGY	28,238	0	0	55.00
57.00	05700	CT SCAN	79,714	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	24,674	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,868	0	0	59.00
60.00	06000	LABORATORY	143,651	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	9,615	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	31,644	0	0	65.00
66.00	06600	PHYSICAL THERAPY	65,017	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	03610	SLEEP LAB	9,751	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	84,322	0	0	71.00
71.01	07101	IV SOLUTIONS	13,730	0	0	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	95,050	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	282,448	0	0	73.00
76.00	03140	CARDIOLOGY	51,698	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,491	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	659	0	0	90.00
91.00	09100	EMERGENCY	106,865	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	23,296	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,461,310	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	194.00
194.01	07951	MOB	0	0	0	194.01
194.02	07952	PHYSICIAN CLINICS	0	0	0	194.02
194.03	07953	PHYS PRAC BUS OFC	0	0	0	194.03
194.04	07954	MOB - MAIN CAMPUS	0	0	0	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	0	0	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	0	0	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	0	0	194.08
194.09	07959	KDH - MC ENT	0	0	0	194.09
194.10	07960	KDH - MC UROLOGY	0	0	0	194.10

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0069			Period: From 01/01/2016 To 12/31/2016		Worksheet B Part I Date/Time Prepared: 5/22/2017 11:00 am	
Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	RADIOLOGY SCHOOL	HUB SITE - 3RD YEAR MED STUDENTS		
			16.00	17.00	19.00	23.00	23.01		
194.11	07961	KDH - MC OB/GYN	0	0	0	0	0		194.11
200.00		Cross Foot Adjustments				0	0		200.00
201.00		Negative Cost Centers	0	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	1,461,310	0	0	162,901	0		202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 5/22/2017 11:00 am
Cost Center	Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
		24.00	25.00	26.00
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
1.01	00101			1.01
2.00	00200			2.00
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
11.00	01100			11.00
13.00	01300			13.00
14.00	01400			14.00
15.00	01500			15.00
16.00	01600			16.00
17.00	01700			17.00
19.00	01900			19.00
23.00	02300			23.00
23.01	02301			23.01
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	11,942,719	0	11,942,719
31.00	03100	1,634,424	0	1,634,424
43.00	04300	591,424	0	591,424
ANCILLARY SERVICE COST CENTERS				
50.00	05000	5,120,394	0	5,120,394
51.00	05100	540,162	0	540,162
52.00	05200	652,238	0	652,238
53.00	05300	332,300	0	332,300
54.00	05400	3,542,845	0	3,542,845
54.01	03630	415,294	0	415,294
54.02	03450	426,784	0	426,784
55.00	03480	2,671,716	0	2,671,716
57.00	05700	772,159	0	772,159
58.00	05800	468,075	0	468,075
59.00	05900	389,855	0	389,855
60.00	06000	6,123,589	0	6,123,589
62.00	06200	327,912	0	327,912
65.00	06500	1,042,941	0	1,042,941
66.00	06600	3,721,728	0	3,721,728
67.00	06700	0	0	0
68.00	06800	0	0	0
69.00	06900	0	0	0
69.01	03610	356,952	0	356,952
71.00	07100	3,998,007	0	3,998,007
71.01	07101	131,147	0	131,147
72.00	07200	5,152,687	0	5,152,687
73.00	07300	7,839,489	0	7,839,489
76.00	03140	1,246,364	0	1,246,364
76.97	07697	177,042	0	177,042
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	257,287	0	257,287
91.00	09100	3,652,074	0	3,652,074
92.00	09200		0	
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	2,735,238	0	2,735,238
101.00	10100	1,469,169	0	1,469,169
SPECIAL PURPOSE COST CENTERS				
113.00	11300			113.00
116.00	11600	226,841	0	226,841
118.00		67,958,856	0	67,958,856
NONREIMBURSABLE COST CENTERS				
190.00	19000	116,695	0	116,695
194.00	07950	5,161	0	5,161
194.01	07951	5,598,026	0	5,598,026
194.02	07952	11,795,081	0	11,795,081
194.03	07953	2,245,733	0	2,245,733
194.04	07954	3,647,792	0	3,647,792
194.05	07955	6,975	0	6,975
194.06	07956	6,346,496	0	6,346,496
194.07	07957	5,218,849	0	5,218,849
194.08	07958	1,735,570	0	1,735,570

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

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

Worksheet B
Part I
Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
194.09	07959 KDH - MC ENT	699,770	0	699,770	194.09
194.10	07960 KDH - MC UROLOGY	839,900	0	839,900	194.10
194.11	07961 KDH - MC OB/GYN	3,126,249	0	3,126,249	194.11
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)	109,341,153	0	109,341,153	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/22/2017 11:00 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP		
		0	1.00	1.01		2.00
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,832,403	0	5.00
7.00	00700	OPERATION OF PLANT	0	2,161,966	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	80,459	0	8.00
9.00	00900	HOUSEKEEPING	0	141,035	0	9.00
10.00	01000	DIETARY	0	265,649	0	10.00
11.00	01100	CAFETERIA	0	107,433	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	94,305	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	130,693	0	14.00
15.00	01500	PHARMACY	0	97,133	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	247,202	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
23.00	02300	RADIOLOGY SCHOOL	0	27,903	0	23.00
23.01	02301	HUB SITE - 3RD YEAR MED STUDENTS	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,680,181	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	70,665	0	31.00
43.00	04300	NURSERY	0	82,527	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	742,198	0	50.00
51.00	05100	RECOVERY ROOM	0	58,044	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	5,488	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	457,636	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	20,389	0	54.02
55.00	03480	ONCOLOGY	0	522,181	0	55.00
57.00	05700	CT SCAN	0	37,781	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	45,591	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	36,050	0	59.00
60.00	06000	LABORATORY	0	263,370	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	11,778	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	50,530	0	65.00
66.00	06600	PHYSICAL THERAPY	0	597,616	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	03610	SLEEP LAB	0	35,417	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
71.01	07101	IV SOLUTIONS	0	0	0	71.01
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	03140	CARDIOLOGY	0	255,265	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	29,676	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	32,082	0	90.00
91.00	09100	EMERGENCY	0	585,881	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	199,754	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	22,559	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE	0	0	0	113.00
116.00	11600	HOSPICE	0	0	6,108	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	11,006,281	28,667	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	194.00
194.01	07951	MOB	0	1,737,676	0	194.01
194.02	07952	PHYSICIAN CLINICS	0	1,485,661	0	194.02
194.03	07953	PHYS PRAC BUS OFC	0	41,749	0	194.03
194.04	07954	MOB - MAIN CAMPUS	0	1,821,343	0	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	0	0	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	0	0	194.07

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0069

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

Worksheet B
Part II
Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP		
		0	1.00	1.01		
194.08 07958 KDH - MC GENERAL SURGERY	0	0	0	0	0	194.08
194.09 07959 KDH - MC ENT	0	0	0	0	0	194.09
194.10 07960 KDH - MC UROLOGY	0	0	0	0	0	194.10
194.11 07961 KDH - MC OB/GYN	0	0	0	0	0	194.11
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	16,092,710	28,667	0	16,121,377	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/22/2017 11:00 am		
Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT 4.00	ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,832,403			5.00
7.00	00700	OPERATION OF PLANT	0	103,586	2,265,552		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,244	14,924	103,627	8.00
9.00	00900	HOUSEKEEPING	0	27,453	26,160	0	194,648
10.00	01000	DIETARY	0	16,616	49,273	0	0
11.00	01100	CAFETERIA	0	9,409	19,927	0	0
13.00	01300	NURSING ADMINISTRATION	0	6,393	17,492	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,009	24,241	0	2,016
15.00	01500	PHARMACY	0	125,081	18,017	0	2,649
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,096	45,852	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
23.00	02300	RADIOLOGY SCHOOL	0	2,347	5,176	0	678
23.01	02301	HUB SITE - 3RD YEAR MED STUDENTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	140,925	311,645	37,240	94,802
31.00	03100	INTENSIVE CARE UNIT	0	23,650	13,107	0	4,159
43.00	04300	NURSERY	0	8,654	15,307	0	828
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	65,737	137,665	20,612	12,963
51.00	05100	RECOVERY ROOM	0	7,527	10,766	2,366	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,949	0	0	2,467
53.00	05300	ANESTHESIOLOGY	0	4,458	1,018	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,267	84,884	6,438	7,311
54.01	03630	ULTRA SOUND	0	3,791	0	705	816
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	6,109	3,782	433	491
55.00	03480	ONCOLOGY	0	37,709	96,856	2,746	9,806
57.00	05700	CT SCAN	0	10,752	7,008	3,050	795
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	6,834	8,456	824	613
59.00	05900	CARDIAC CATHETERIZATION	0	5,640	6,687	0	1,663
60.00	06000	LABORATORY	0	95,550	48,851	0	5,558
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	5,234	2,185	0	0
65.00	06500	RESPIRATORY THERAPY	0	16,239	9,372	0	0
66.00	06600	PHYSICAL THERAPY	0	54,577	110,848	6,905	2,069
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	0
69.01	03610	SLEEP LAB	0	5,193	6,569	413	1,676
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	65,589	0	0	0
71.01	07101	IV SOLUTIONS	0	1,968	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	84,760	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03140	CARDIOLOGY	0	17,020	47,347	3,218	2,061
76.97	07697	CARDIAC REHABILITATION	0	2,481	5,504	0	917
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	3,838	5,951	1	974
91.00	09100	EMERGENCY	0	48,178	108,671	14,790	15,783
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	42,550	37,051	2,305	0
101.00	10100	HOME HEALTH AGENCY	0	23,588	21,517	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	0	3,802	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,186,803	1,322,109	102,046	171,095
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,951	0	0	0
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0
194.01	07951	MOB	0	78,599	322,309	210	0
194.02	07952	PHYSICIAN CLINICS	0	185,003	275,565	471	0
194.03	07953	PHYS PRAC BUS OFC	0	37,282	7,744	0	0
194.04	07954	MOB - MAIN CAMPUS	0	42,220	337,825	0	23,553
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	0
194.06	07956	KDH - MC FAMILY PRACTICE	0	106,223	0	43	0
194.07	07957	KDH - MC ORTHOPEDICS	0	87,349	0	198	0
194.08	07958	KDH - MC GENERAL SURGERY	0	29,014	0	235	0
194.09	07959	KDH - MC ENT	0	11,667	0	0	0
194.10	07960	KDH - MC UROLOGY	0	13,936	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0069

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

Worksheet B
Part II
Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT 4.00	ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	
194.11	07961 KDH - MC OB/GYN	0	52,356	0	424	0	194.11
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,832,403	2,265,552	103,627	194,648	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0069		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 5/22/2017 11:00 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	331,538					10.00
11.00	01100	CAFETERIA	0	136,769				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,311	119,501			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	914	0	168,873		14.00
15.00	01500	PHARMACY	0	3,592	0	1,099	247,571	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,941	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	RADIOLOGY SCHOOL	0	614	0	0	0	23.00
23.01	02301	HUB SITE - 3RD YEAR MED STUDENTS	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	306,454	29,074	57,428	46,339	0	30.00
31.00	03100	INTENSIVE CARE UNIT	25,084	4,463	8,815	19	0	31.00
43.00	04300	NURSERY	0	1,584	3,129	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	11,774	23,256	71,323	0	50.00
51.00	05100	RECOVERY ROOM	0	1,303	2,574	775	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,246	4,437	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,740	0	4,754	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,668	0	1,079	0	54.00
54.01	03630	ULTRA SOUND	0	566	0	689	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	440	0	3,328	0	54.02
55.00	03480	ONCOLOGY	0	4,492	0	1,971	0	55.00
57.00	05700	CT SCAN	0	1,296	0	733	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	649	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,072	0	406	0	59.00
60.00	06000	LABORATORY	0	12,762	0	8,817	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	3,610	0	107	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,383	0	405	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	03610	SLEEP LAB	0	575	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
71.01	07101	IV SOLUTIONS	0	0	0	0	0	71.01
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	247,571	73.00
76.00	03140	CARDIOLOGY	0	2,914	0	489	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	536	0	9	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	611	0	12	0	90.00
91.00	09100	EMERGENCY	0	10,055	19,862	9,462	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	12,536	0	817	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	674	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	331,538	136,721	119,501	153,307	247,571	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	66	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	1,170	0	194.00
194.01	07951	MOB	0	0	0	6,262	0	194.01
194.02	07952	PHYSICIAN CLINICS	0	48	0	0	0	194.02
194.03	07953	PHYS PRAC BUS OFC	0	0	0	0	0	194.03
194.04	07954	MOB - MAIN CAMPUS	0	0	0	0	0	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	1,581	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	0	0	1,792	0	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	0	0	1,295	0	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	0	0	707	0	194.08
194.09	07959	KDH - MC ENT	0	0	0	809	0	194.09
194.10	07960	KDH - MC UROLOGY	0	0	0	1,884	0	194.10

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0069		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 5/22/2017 11:00 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
194.11	07961	KDH - MC OB/GYN	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	331,538	136,769	119,501	168,873	247,571	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/22/2017 11:00 am		
Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	RADIOLOGY SCHOOL	HUB SITE - 3RD YEAR MED STUDENTS
			16.00	17.00	19.00	23.00	23.01
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	319,091				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
23.00	02300	RADIOLOGY SCHOOL	0	0		36,718	23.00
23.01	02301	HUB SITE - 3RD YEAR MED STUDENTS	0	0			23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	16,239	0			30.00
31.00	03100	INTENSIVE CARE UNIT	2,947	0			31.00
43.00	04300	NURSERY	1,636	0			43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	32,812	0			50.00
51.00	05100	RECOVERY ROOM	6,731	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,320	0			52.00
53.00	05300	ANESTHESIOLOGY	6,601	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,272	0			54.00
54.01	03630	ULTRA SOUND	2,137	0			54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	6,275	0			54.02
55.00	03480	ONCOLOGY	6,168	0			55.00
57.00	05700	CT SCAN	17,412	0			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,389	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	3,029	0			59.00
60.00	06000	LABORATORY	31,378	0			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,100	0			62.00
65.00	06500	RESPIRATORY THERAPY	6,912	0			65.00
66.00	06600	PHYSICAL THERAPY	14,201	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	03610	SLEEP LAB	2,130	0			69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,418	0			71.00
71.01	07101	IV SOLUTIONS	2,999	0			71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,762	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,593	0			73.00
76.00	03140	CARDIOLOGY	11,292	0			76.00
76.97	07697	CARDIAC REHABILITATION	763	0			76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	144	0			90.00
91.00	09100	EMERGENCY	23,342	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	5,089	0			95.00
101.00	10100	HOME HEALTH AGENCY	0	0			101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0			116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	319,091	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0			190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0			194.00
194.01	07951	MOB	0	0			194.01
194.02	07952	PHYSICIAN CLINICS	0	0			194.02
194.03	07953	PHYS PRAC BUS OFC	0	0			194.03
194.04	07954	MOB - MAIN CAMPUS	0	0			194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0			194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	0			194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	0			194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	0			194.08
194.09	07959	KDH - MC ENT	0	0			194.09
194.10	07960	KDH - MC UROLOGY	0	0			194.10

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0069		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 5/22/2017 11:00 am	
Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	RADIOLOGY SCHOOL	HUB SITE - 3RD YEAR MED STUDENTS	
			16.00	17.00	19.00	23.00	23.01	
194.11	07961	KDH - MC OB/GYN	0	0				194.11
200.00		Cross Foot Adjustments			0	36,718		0 200.00
201.00		Negative Cost Centers	0	0	0	0		0 201.00
202.00		TOTAL (sum lines 118-201)	319,091	0	0	36,718		0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/22/2017 11:00 am
Cost Center	Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
		24.00	25.00	26.00
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
1.01	00101			1.01
2.00	00200			2.00
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
11.00	01100			11.00
13.00	01300			13.00
14.00	01400			14.00
15.00	01500			15.00
16.00	01600			16.00
17.00	01700			17.00
19.00	01900			19.00
23.00	02300			23.00
23.01	02301			23.01
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	2,720,327	0	2,720,327
31.00	03100	152,909	0	152,909
43.00	04300	113,665	0	113,665
ANCILLARY SERVICE COST CENTERS				
50.00	05000	1,118,340	0	1,118,340
51.00	05100	90,086	0	90,086
52.00	05200	21,419	0	21,419
53.00	05300	25,059	0	25,059
54.00	05400	629,555	0	629,555
54.01	03630	8,704	0	8,704
54.02	03450	41,247	0	41,247
55.00	03480	681,929	0	681,929
57.00	05700	78,827	0	78,827
58.00	05800	68,356	0	68,356
59.00	05900	54,547	0	54,547
60.00	06000	466,286	0	466,286
62.00	06200	21,297	0	21,297
65.00	06500	86,770	0	86,770
66.00	06600	796,004	0	796,004
67.00	06700	0	0	0
68.00	06800	0	0	0
69.00	06900	0	0	0
69.01	03610	51,973	0	51,973
71.00	07100	84,007	0	84,007
71.01	07101	4,967	0	4,967
72.00	07200	105,522	0	105,522
73.00	07300	309,164	0	309,164
76.00	03140	339,606	0	339,606
76.97	07697	39,886	0	39,886
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	43,613	0	43,613
91.00	09100	836,024	0	836,024
92.00	09200		0	
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	300,102	0	300,102
101.00	10100	68,338	0	68,338
SPECIAL PURPOSE COST CENTERS				
113.00	11300			113.00
116.00	11600	9,910	0	9,910
118.00		9,368,439	0	9,368,439
NONREIMBURSABLE COST CENTERS				
190.00	19000	2,017	0	2,017
194.00	07950	1,170	0	1,170
194.01	07951	2,145,056	0	2,145,056
194.02	07952	1,946,748	0	1,946,748
194.03	07953	86,775	0	86,775
194.04	07954	2,224,941	0	2,224,941
194.05	07955	1,581	0	1,581
194.06	07956	108,058	0	108,058
194.07	07957	88,842	0	88,842
194.08	07958	29,956	0	29,956

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0069		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 5/22/2017 11:00 am	
Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total			
			24.00	25.00	26.00			
194.09	07959	KDH - MC ENT	12,476	0	12,476			194.09
194.10	07960	KDH - MC UROLOGY	15,820	0	15,820			194.10
194.11	07961	KDH - MC OB/GYN	52,780	0	52,780			194.11
200.00		Cross Foot Adjustments	36,718	0	36,718			200.00
201.00		Negative Cost Centers	0	0	0			201.00
202.00		TOTAL (sum lines 118-201)	16,121,377	0	16,121,377			202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		NEW BLDG & FIXT (SQUARE FEET)	NEW BLDG & FIXT HHA/HO (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)			
		1.00	1.01	2.00			
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	381,222				1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	3,492			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			382,644		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	50,906,802		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	43,408	0	43,408	6,262,406	-17,134,233
7.00	00700	OPERATION OF PLANT	51,215	0	51,215	637,202	0
8.00	00800	LAUNDRY & LINEN SERVICE	1,906	0	1,906	42,182	0
9.00	00900	HOUSEKEEPING	3,341	0	3,341	657,614	0
10.00	01000	DIETARY	6,293	0	6,293	311,099	0
11.00	01100	CAFETERIA	2,545	0	2,545	373,483	0
13.00	01300	NURSING ADMINISTRATION	2,234	0	2,234	284,194	0
14.00	01400	CENTRAL SERVICES & SUPPLY	3,096	0	3,096	78,171	0
15.00	01500	PHARMACY	2,301	0	231	811,431	0
16.00	01600	MEDICAL RECORDS & LIBRARY	5,856	0	5,856	507,896	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
23.00	02300	RADIOLOGY SCHOOL	661	0	661	103,830	0
23.01	02301	HUB SITE - 3RD YEAR MED STUDENTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	39,802	0	39,802	4,313,022	0
31.00	03100	INTENSIVE CARE UNIT	1,674	0	1,674	919,320	0
43.00	04300	NURSERY	1,955	0	1,955	277,814	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	17,582	0	17,582	1,919,212	0
51.00	05100	RECOVERY ROOM	1,375	0	1,375	263,599	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	394,747	0
53.00	05300	ANESTHESIOLOGY	130	0	130	743,336	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,841	0	10,841	2,514,358	0
54.01	03630	ULTRA SOUND	0	0	0	112,090	0
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	483	0	483	73,917	0
55.00	03480	ONCOLOGY	12,370	0	12,370	1,138,556	0
57.00	05700	CT SCAN	895	0	895	203,432	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,080	0	1,080	132,446	0
59.00	05900	CARDIAC CATHETERIZATION	854	0	854	200,972	0
60.00	06000	LABORATORY	6,239	0	6,239	1,552,525	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	279	0	279	0	0
65.00	06500	RESPIRATORY THERAPY	1,197	0	1,197	590,449	0
66.00	06600	PHYSICAL THERAPY	14,157	0	14,157	1,740,746	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	0
69.01	03610	SLEEP LAB	839	0	839	132,415	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
71.01	07101	IV SOLUTIONS	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	03140	CARDIOLOGY	6,047	0	6,047	422,532	0
76.97	07697	CARDIAC REHABILITATION	703	0	703	71,656	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	760	0	760	132,557	0
91.00	09100	EMERGENCY	13,879	0	13,879	1,493,720	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	4,732	0	4,732	1,456,917	0
101.00	10100	HOME HEALTH AGENCY	0	2,748	2,748	889,957	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	744	744	68,245	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	260,729	3,492	262,151	31,828,048	-17,134,233
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0
194.01	07951	MOB	41,164	0	41,164	1,550,700	0
194.02	07952	PHYSICIAN CLINICS	35,194	0	35,194	5,280,099	0
194.03	07953	PHYS PRAC BUS OFC	989	0	989	641,268	0
194.04	07954	MOB - MAIN CAMPUS	43,146	0	43,146	217,649	0
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	0
194.06	07956	KDH - MC FAMILY PRACTICE	0	0	0	4,264,092	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEET)	NEW BLDG & FIXT HHA/HO (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)			
	1.00	1.01	2.00			
194.07 07957 KDH - MC ORTHOPEDICS	0	0	0	3,570,734	0	194.07
194.08 07958 KDH - MC GENERAL SURGERY	0	0	0	1,092,600	0	194.08
194.09 07959 KDH - MC ENT	0	0	0	570,366	0	194.09
194.10 07960 KDH - MC UROLOGY	0	0	0	89,339	0	194.10
194.11 07961 KDH - MC OB/GYN	0	0	0	1,801,907	0	194.11
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)	16,092,710	28,667	0	10,717,587		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	42.213487	8.209336	0.000000	0.210533		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet B-1 Date/Time Prepared: 5/22/2017 11:00 am		
Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO					1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL	92,206,920				5.00
7.00 00700	OPERATION OF PLANT	5,212,391	289,347			7.00
8.00 00800	LAUNDRY & LINEN SERVICE	414,852	1,906	453,349		8.00
9.00 00900	HOUSEKEEPING	1,381,446	3,341	0	47,975	9.00
10.00 01000	DIETARY	836,096	6,293	0	0	47,898 10.00
11.00 01100	CAFETERIA	473,477	2,545	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	321,687	2,234	0	0	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	553,961	3,096	0	497	0 14.00
15.00 01500	PHARMACY	6,294,017	2,301	0	653	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,111,859	5,856	0	0	0 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
23.00 02300	RADIOLOGY SCHOOL	118,117	661	0	167	0 23.00
23.01 02301	HUB SITE - 3RD YEAR MED STUDENTS	0	0	0	0	0 23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,091,263	39,802	162,923	23,366	44,274 30.00
31.00 03100	INTENSIVE CARE UNIT	1,190,047	1,674	0	1,025	3,624 31.00
43.00 04300	NURSERY	435,462	1,955	0	204	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,307,841	17,582	90,174	3,195	0 50.00
51.00 05100	RECOVERY ROOM	378,773	1,375	10,350	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	500,654	0	0	608	0 52.00
53.00 05300	ANESTHESIOLOGY	224,314	130	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,630,060	10,841	28,166	1,802	0 54.00
54.01 03630	ULTRA SOUND	190,783	0	3,085	201	0 54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	307,417	483	1,895	121	0 54.02
55.00 03480	ONCOLOGY	1,897,474	12,370	12,013	2,417	0 55.00
57.00 05700	CT SCAN	541,057	895	13,343	196	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	343,892	1,080	3,603	151	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	283,780	854	0	410	0 59.00
60.00 06000	LABORATORY	4,808,044	6,239	0	1,370	0 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	263,392	279	0	0	0 62.00
65.00 06500	RESPIRATORY THERAPY	817,156	1,197	0	0	0 65.00
66.00 06600	PHYSICAL THERAPY	2,746,274	14,157	30,206	510	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 03610	SLEEP LAB	261,292	839	1,808	413	0 69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,300,393	0	0	0	0 71.00
71.01 07101	IV SOLUTIONS	99,017	0	0	0	0 71.01
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	4,265,082	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00 03140	CARDIOLOGY	856,424	6,047	14,077	508	0 76.00
76.97 07697	CARDIAC REHABILITATION	124,835	703	0	226	0 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	193,141	760	5	240	0 90.00
91.00 09100	EMERGENCY	2,424,275	13,879	64,705	3,890	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	2,141,096	4,732	10,082	0	0 95.00
101.00 10100	HOME HEALTH AGENCY	1,186,932	2,748	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	191,294	0	0	0	0 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	59,719,367	168,854	446,435	42,170	47,898 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	98,164	0	0	0	0 190.00
194.00 07950	OTHER NON-REIMBURSABLE	0	0	0	0	0 194.00
194.01 07951	MOB	3,955,047	41,164	918	0	0 194.01
194.02 07952	PHYSICIAN CLINICS	9,310,536	35,194	2,061	0	0 194.02
194.03 07953	PHYS PRAC BUS OFC	1,876,000	989	0	0	0 194.03
194.04 07954	MOB - MAIN CAMPUS	2,124,482	43,146	0	5,805	0 194.04
194.05 07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	0 194.05
194.06 07956	KDH - MC FAMILY PRACTICE	5,345,116	0	190	0	0 194.06
194.07 07957	KDH - MC ORTHOPEDICS	4,395,359	0	865	0	0 194.07
194.08 07958	KDH - MC GENERAL SURGERY	1,459,953	0	1,026	0	0 194.08
194.09 07959	KDH - MC ENT	587,103	0	0	0	0 194.09

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
194.10	07960 KDH - MC UROLOGY	701,278	0	0	0	0	194.10
194.11	07961 KDH - MC OB/GYN	2,634,515	0	1,854	0	0	194.11
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)	17,134,233	6,180,978	532,657	1,709,522	1,125,893	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.185824	21.361818	1.174938	35.633601	23.506055	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,832,403	2,265,552	103,627	194,648	331,538	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.019873	7.829879	0.228581	4.057280	6.921750	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATIVE (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
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
11.00	01100	856,516					11.00
13.00	01300	8,208	378,876				13.00
14.00	01400	5,727	0	469,962			14.00
15.00	01500	22,496	0	3,059	100		15.00
16.00	01600	24,682	0	0	0	264,034,972	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	3,844	0	0	0	0	23.00
23.01	02301	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	182,077	182,077	128,959	0	13,431,834	30.00
31.00	03100	27,949	27,949	54	0	2,437,444	31.00
43.00	04300	9,919	9,919	0	0	1,352,948	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	73,733	73,733	198,488	0	27,140,154	50.00
51.00	05100	8,160	8,160	2,157	0	5,567,071	51.00
52.00	05200	14,066	14,066	0	0	1,918,586	52.00
53.00	05300	17,160	0	13,230	0	5,459,660	53.00
54.00	05400	73,073	0	3,003	0	6,841,923	54.00
54.01	03630	3,544	0	1,918	0	1,767,402	54.01
54.02	03450	2,753	0	9,261	0	5,190,252	54.02
55.00	03480	28,134	0	5,485	0	5,101,654	55.00
57.00	05700	8,115	0	2,039	0	14,401,773	57.00
58.00	05800	4,062	0	0	0	4,457,809	58.00
59.00	05900	6,715	0	1,131	0	2,505,427	59.00
60.00	06000	79,921	0	24,536	0	25,953,292	60.00
62.00	06200	0	0	0	0	1,737,189	62.00
65.00	06500	22,606	0	297	0	5,717,009	65.00
66.00	06600	58,758	0	1,126	0	11,746,480	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	0	0	69.00
69.01	03610	3,603	0	0	0	1,761,739	69.01
71.00	07100	0	0	0	0	15,234,346	71.00
71.01	07101	0	0	0	0	2,480,615	71.01
72.00	07200	0	0	0	0	17,172,490	72.00
73.00	07300	0	0	0	100	51,051,829	73.00
76.00	03140	18,251	0	1,362	0	9,340,168	76.00
76.97	07697	3,354	0	24	0	630,743	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	3,827	0	33	0	119,128	90.00
91.00	09100	62,972	62,972	26,332	0	19,307,073	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	78,508	0	2,273	0	4,208,934	95.00
101.00	10100	0	0	1,877	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	0	0	116.00
118.00		856,217	378,876	426,644	100	264,034,972	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	183	0	0	190.00
194.00	07950	0	0	3,256	0	0	194.00
194.01	07951	0	0	17,426	0	0	194.01
194.02	07952	299	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	4,401	0	0	194.05
194.06	07956	0	0	4,988	0	0	194.06
194.07	07957	0	0	3,603	0	0	194.07
194.08	07958	0	0	1,967	0	0	194.08

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
194.09	07959 KDH - MC ENT	0	0	2,252	0	0	194.09
194.10	07960 KDH - MC UROLOGY	0	0	5,242	0	0	194.10
194.11	07961 KDH - MC OB/GYN	0	0	0	0	0	194.11
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)	615,826	435,087	744,864	7,557,041	1,461,310	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.718989	1.148363	1.584945	75,570.410000	0.005535	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	136,769	119,501	168,873	247,571	319,091	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.159681	0.315409	0.359333	2,475.710000	0.001209	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1
Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	RADIOLOGY SCHOOL (ASSIGNED TIME)	HUB SITE - 3RD YEAR MED STUDENTS (ASSIGNED TIME)	
		17.00	19.00	23.00	23.01	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
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	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
23.00	02300	RADIOLOGY SCHOOL	0	1,000		23.00
23.01	02301	HUB SITE - 3RD YEAR MED STUDENTS	0		0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
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
54.01	03630	ULTRA SOUND	0	1,000	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	54.02
55.00	03480	ONCOLOGY	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
69.01	03610	SLEEP LAB	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
71.01	07101	IV SOLUTIONS	0	0	0	71.01
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	03140	CARDIOLOGY	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
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
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	1,000	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	194.00
194.01	07951	MOB	0	0	0	194.01
194.02	07952	PHYSICIAN CLINICS	0	0	0	194.02
194.03	07953	PHYS PRAC BUS OFC	0	0	0	194.03
194.04	07954	MOB - MAIN CAMPUS	0	0	0	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	0	0	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	0	0	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	0	0	194.08

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	RADIOLOGY SCHOOL (ASSIGNED TIME)	HUB SITE - 3RD YEAR MED STUDENTS (ASSIGNED TIME)		
		17.00	19.00	23.00	23.01		
194.09	07959 KDH - MC ENT	0	0	0	0		194.09
194.10	07960 KDH - MC UROLOGY	0	0	0	0		194.10
194.11	07961 KDH - MC OB/GYN	0	0	0	0		194.11
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)	0	0	162,901	0		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	162.901000	0.000000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0	36,718	0		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	36.718000	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/22/2017 11:00 am	
		Title XVIII	Hospital	PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
			Total Costs	RCE Disallowance	
	1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		11,942,719	0	11,942,719
31.00	03100 INTENSIVE CARE UNIT		1,634,424	0	1,634,424
43.00	04300 NURSERY		591,424	0	591,424
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		5,120,394	0	5,120,394
51.00	05100 RECOVERY ROOM		540,162	0	540,162
52.00	05200 DELIVERY ROOM & LABOR ROOM		652,238	0	652,238
53.00	05300 ANESTHESIOLOGY		332,300	0	332,300
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,542,845	0	3,542,845
54.01	03630 ULTRA SOUND		415,294	0	415,294
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC		426,784	0	426,784
55.00	03480 ONCOLOGY		2,671,716	0	2,671,716
57.00	05700 CT SCAN		772,159	0	772,159
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		468,075	0	468,075
59.00	05900 CARDIAC CATHETERIZATION		389,855	0	389,855
60.00	06000 LABORATORY		6,123,589	61,868	6,185,457
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		327,912	0	327,912
65.00	06500 RESPIRATORY THERAPY	0	1,042,941	0	1,042,941
66.00	06600 PHYSICAL THERAPY	0	3,721,728	0	3,721,728
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800 SPEECH PATHOLOGY	0	0	0	0
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0
69.01	03610 SLEEP LAB		356,952	0	356,952
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		3,998,007	0	3,998,007
71.01	07101 IV SOLUTIONS		131,147	0	131,147
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		5,152,687	0	5,152,687
73.00	07300 DRUGS CHARGED TO PATIENTS		7,839,489	0	7,839,489
76.00	03140 RADIOLOGY		1,246,364	0	1,246,364
76.97	07697 CARDIAC REHABILITATION		177,042	0	177,042
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC		257,287	0	257,287
91.00	09100 EMERGENCY		3,652,074	0	3,652,074
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		2,817,689	0	2,817,689
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES		2,735,238	63	2,735,301
101.00	10100 HOME HEALTH AGENCY		1,469,169	0	1,469,169
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				
116.00	11600 HOSPICE		226,841		226,841
200.00	Subtotal (see instructions)	0	70,776,545	61,931	70,838,476
201.00	Less Observation Beds		2,817,689		2,817,689
202.00	Total (see instructions)	0	67,958,856	61,931	68,020,787

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0069

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

Worksheet C
Part I
Date/Time Prepared:
5/22/2017 11:00 am

		Title XVIII			Hospital	PPS	
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	13,431,834		13,431,834		30.00
31.00	03100	INTENSIVE CARE UNIT	2,437,444		2,437,444		31.00
43.00	04300	NURSERY	1,352,948		1,352,948		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,737,627	20,402,527	27,140,154	0.188665	50.00
51.00	05100	RECOVERY ROOM	1,572,066	3,995,006	5,567,072	0.097028	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,901,972	16,614	1,918,586	0.339958	52.00
53.00	05300	ANESTHESIOLOGY	1,572,331	3,887,330	5,459,661	0.060865	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,217,380	5,624,544	6,841,924	0.517814	54.00
54.01	03630	ULTRA SOUND	214,907	1,552,495	1,767,402	0.234974	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	328,600	4,861,652	5,190,252	0.082228	54.02
55.00	03480	ONCOLOGY	115,631	4,986,023	5,101,654	0.523696	55.00
57.00	05700	CT SCAN	2,147,263	12,254,510	14,401,773	0.053616	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	211,480	4,246,329	4,457,809	0.105001	58.00
59.00	05900	CARDIAC CATHETERIZATION	519,000	1,986,427	2,505,427	0.155604	59.00
60.00	06000	LABORATORY	4,689,894	21,263,399	25,953,293	0.235947	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	862,787	874,402	1,737,189	0.188760	62.00
65.00	06500	RESPIRATORY THERAPY	4,178,508	1,538,500	5,717,008	0.182428	65.00
66.00	06600	PHYSICAL THERAPY	1,286,445	10,460,035	11,746,480	0.316838	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
69.01	03610	SLEEP LAB	0	1,761,739	1,761,739	0.202613	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,029,403	5,463,933	11,493,336	0.347854	71.00
71.01	07101	IV SOLUTIONS	1,321,825	1,158,790	2,480,615	0.052869	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,136,360	5,036,130	17,172,490	0.300055	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,164,935	29,886,894	51,051,829	0.153559	73.00
76.00	03140	CARDIOLOGY	1,694,557	7,645,611	9,340,168	0.133441	76.00
76.97	07697	CARDIAC REHABILITATION	1,242	629,501	630,743	0.280688	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	119,128	119,128	2.159753	90.00
91.00	09100	EMERGENCY	3,535,819	19,512,264	23,048,083	0.158455	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	626,895	2,076,228	2,703,123	1.042383	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,669	4,206,265	4,208,934	0.649865	95.00
101.00	10100	HOME HEALTH AGENCY	0	2,057,900	2,057,900		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	452,548	452,548		116.00
200.00		Subtotal (see instructions)	91,291,822	177,956,724	269,248,546		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	91,291,822	177,956,724	269,248,546		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/22/2017 11:00 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		PPS
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	0.188665		50.00
51.00	05100 RECOVERY ROOM	0.097028		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.339958		52.00
53.00	05300 ANESTHESIOLOGY	0.060865		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.517814		54.00
54.01	03630 ULTRA SOUND	0.234974		54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.082228		54.02
55.00	03480 ONCOLOGY	0.523696		55.00
57.00	05700 CT SCAN	0.053616		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.105001		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.155604		59.00
60.00	06000 LABORATORY	0.238330		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.188760		62.00
65.00	06500 RESPIRATORY THERAPY	0.182428		65.00
66.00	06600 PHYSICAL THERAPY	0.316838		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	03610 SLEEP LAB	0.202613		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.347854		71.00
71.01	07101 IV SOLUTIONS	0.052869		71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.300055		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.153559		73.00
76.00	03140 RADIOLOGY	0.133441		76.00
76.97	07697 CARDIAC REHABILITATION	0.280688		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	2.159753		90.00
91.00	09100 EMERGENCY	0.158455		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.042383		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.649880		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0069

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

Worksheet C
Part I
Date/Time Prepared:
5/22/2017 11:00 am

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	11,942,719		11,942,719	0	11,942,719 30.00
31.00	03100 INTENSIVE CARE UNIT	1,634,424		1,634,424	0	1,634,424 31.00
43.00	04300 NURSERY	591,424		591,424	0	591,424 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5,120,394		5,120,394	0	5,120,394 50.00
51.00	05100 RECOVERY ROOM	540,162		540,162	0	540,162 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	652,238		652,238	0	652,238 52.00
53.00	05300 ANESTHESIOLOGY	332,300		332,300	0	332,300 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,542,845		3,542,845	0	3,542,845 54.00
54.01	03630 ULTRA SOUND	415,294		415,294	0	415,294 54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	426,784		426,784	0	426,784 54.02
55.00	03480 ONCOLOGY	2,671,716		2,671,716	0	2,671,716 55.00
57.00	05700 CT SCAN	772,159		772,159	0	772,159 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	468,075		468,075	0	468,075 58.00
59.00	05900 CARDIAC CATHETERIZATION	389,855		389,855	0	389,855 59.00
60.00	06000 LABORATORY	6,123,589		6,123,589	61,868	6,185,457 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	327,912		327,912	0	327,912 62.00
65.00	06500 RESPIRATORY THERAPY	1,042,941	0	1,042,941	0	1,042,941 65.00
66.00	06600 PHYSICAL THERAPY	3,721,728	0	3,721,728	0	3,721,728 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 69.00
69.01	03610 SLEEP LAB	356,952		356,952	0	356,952 69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,998,007		3,998,007	0	3,998,007 71.00
71.01	07101 IV SOLUTIONS	131,147		131,147	0	131,147 71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5,152,687		5,152,687	0	5,152,687 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,839,489		7,839,489	0	7,839,489 73.00
76.00	03140 RADIOLOGY	1,246,364		1,246,364	0	1,246,364 76.00
76.97	07697 CARDIAC REHABILITATION	177,042		177,042	0	177,042 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	257,287		257,287	0	257,287 90.00
91.00	09100 EMERGENCY	3,652,074		3,652,074	0	3,652,074 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,817,689		2,817,689	0	2,817,689 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	2,735,238		2,735,238	63	2,735,301 95.00
101.00	10100 HOME HEALTH AGENCY	1,469,169		1,469,169	0	1,469,169 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
116.00	11600 HOSPICE	226,841		226,841		226,841 116.00
200.00	Subtotal (see instructions)	70,776,545	0	70,776,545	61,931	70,838,476 200.00
201.00	Less Observation Beds	2,817,689		2,817,689		2,817,689 201.00
202.00	Total (see instructions)	67,958,856	0	67,958,856	61,931	68,020,787 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0069		Period: From 01/01/2016 To 12/31/2016		Worksheet C Part I Date/Time Prepared: 5/22/2017 11:00 am		
			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	13,431,834		13,431,834				30.00
31.00	03100	INTENSIVE CARE UNIT	2,437,444		2,437,444				31.00
43.00	04300	NURSERY	1,352,948		1,352,948				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	6,737,627	20,402,527	27,140,154	0.188665	0.000000		50.00
51.00	05100	RECOVERY ROOM	1,572,066	3,995,006	5,567,072	0.097028	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,901,972	16,614	1,918,586	0.339958	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	1,572,331	3,887,330	5,459,661	0.060865	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,217,380	5,624,544	6,841,924	0.517814	0.000000		54.00
54.01	03630	ULTRA SOUND	214,907	1,552,495	1,767,402	0.234974	0.000000		54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	328,600	4,861,652	5,190,252	0.082228	0.000000		54.02
55.00	03480	ONCOLOGY	115,631	4,986,023	5,101,654	0.523696	0.000000		55.00
57.00	05700	CT SCAN	2,147,263	12,254,510	14,401,773	0.053616	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	211,480	4,246,329	4,457,809	0.105001	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	519,000	1,986,427	2,505,427	0.155604	0.000000		59.00
60.00	06000	LABORATORY	4,689,894	21,263,399	25,953,293	0.235947	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	862,787	874,402	1,737,189	0.188760	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	4,178,508	1,538,500	5,717,008	0.182428	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	1,286,445	10,460,035	11,746,480	0.316838	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000		69.00
69.01	03610	SLEEP LAB	0	1,761,739	1,761,739	0.202613	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,029,403	5,463,933	11,493,336	0.347854	0.000000		71.00
71.01	07101	IV SOLUTIONS	1,321,825	1,158,790	2,480,615	0.052869	0.000000		71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,136,360	5,036,130	17,172,490	0.300055	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,164,935	29,886,894	51,051,829	0.153559	0.000000		73.00
76.00	03140	CARDIOLOGY	1,694,557	7,645,611	9,340,168	0.133441	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	1,242	629,501	630,743	0.280688	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	119,128	119,128	2.159753	0.000000		90.00
91.00	09100	EMERGENCY	3,535,819	19,512,264	23,048,083	0.158455	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	626,895	2,076,228	2,703,123	1.042383	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	2,669	4,206,265	4,208,934	0.649865	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY	0	2,057,900	2,057,900				101.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
116.00	11600	HOSPICE	0	452,548	452,548				116.00
200.00		Subtotal (see instructions)	91,291,822	177,956,724	269,248,546				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	91,291,822	177,956,724	269,248,546				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0069

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

Worksheet C
Part I
Date/Time Prepared:
5/22/2017 11:00 am

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
51.00	05100 RECOVERY ROOM	0.000000			51.00
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
54.01	03630 ULTRA SOUND	0.000000			54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000			54.02
55.00	03480 ONCOLOGY	0.000000			55.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
69.01	03610 SLEEP LAB	0.000000			69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
71.01	07101 IV SOLUTIONS	0.000000			71.01
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	03140 RADIOLOGY	0.000000			76.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS					
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					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
116.00	11600 HOSPICE				116.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0069		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part I Date/Time Prepared: 5/22/2017 11:00 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
Title XVIII		Hospital		PPS			
Cost Center Description		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,720,327	0	2,720,327	13,703	198.52	30.00
31.00	INTENSIVE CARE UNIT	152,909		152,909	1,289	118.63	31.00
43.00	NURSERY	113,665		113,665	1,135	100.15	43.00
200.00	Total (Lines 30-199)	2,986,901		2,986,901	16,127		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	5,548	1,101,389				
31.00	INTENSIVE CARE UNIT	773	91,701				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	6,321	1,193,090				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 5/22/2017 11:00 am
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Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from Wkst. C, Part I, 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	1,118,340	27,140,154	0.041206	3,226,840	132,965	50.00
51.00	05100 RECOVERY ROOM	90,086	5,567,072	0.016182	604,181	9,777	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	21,419	1,918,586	0.011164	7,146	80	52.00
53.00	05300 ANESTHESIOLOGY	25,059	5,459,661	0.004590	673,918	3,093	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	629,555	6,841,924	0.092014	810,217	74,551	54.00
54.01	03630 ULTRA SOUND	8,704	1,767,402	0.004925	98,440	485	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	41,247	5,190,252	0.007947	227,768	1,810	54.02
55.00	03480 ONCOLOGY	681,929	5,101,654	0.133668	80,776	10,797	55.00
57.00	05700 CT SCAN	78,827	14,401,773	0.005473	1,348,241	7,379	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	68,356	4,457,809	0.015334	118,665	1,820	58.00
59.00	05900 CARDIAC CATHETERIZATION	54,547	2,505,427	0.021772	353,530	7,697	59.00
60.00	06000 LABORATORY	466,286	25,953,293	0.017966	2,881,350	51,766	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	21,297	1,737,189	0.012259	267,095	3,274	62.00
65.00	06500 RESPIRATORY THERAPY	86,770	5,717,008	0.015178	2,827,805	42,920	65.00
66.00	06600 PHYSICAL THERAPY	796,004	11,746,480	0.067765	815,518	55,264	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	03610 SLEEP LAB	51,973	1,761,739	0.029501	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	84,007	11,493,336	0.007309	2,606,777	19,053	71.00
71.01	07101 IV SOLUTIONS	4,967	2,480,615	0.002002	573,469	1,148	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	105,522	17,172,490	0.006145	6,365,344	39,115	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	309,164	51,051,829	0.006056	12,208,338	73,934	73.00
76.00	03140 RADIOLOGY	339,606	9,340,168	0.036360	1,164,359	42,336	76.00
76.97	07697 CARDIAC REHABILITATION	39,886	630,743	0.063237	1,242	79	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	43,613	119,128	0.366102	0	0	90.00
91.00	09100 EMERGENCY	836,024	23,048,083	0.036273	2,035,784	73,844	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	641,816	2,703,123	0.237435	374,637	88,952	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	6,645,004	245,306,938		39,671,440	742,139	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0069		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part III Date/Time Prepared: 5/22/2017 11:00 am	
Title XVIII			Hospital		PPS			
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	
43.00	04300	NURSERY	0	0	0	0	0	
200.00		Total (lines 30-199)	0	0	0	0	0	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,703	0.00	5,548	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	1,289	0.00	773	0	31.00	
43.00	04300	NURSERY	1,135	0.00	0	0	43.00	
200.00		Total (lines 30-199)	16,127		6,321	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/22/2017 11:00 am
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Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education 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	
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00	
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	
54.01	03630	ULTRA SOUND	0	0	162,901	0	162,901	54.01	
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	54.02	
55.00	03480	ONCOLOGY	0	0	0	0	0	55.00	
57.00	05700	CT SCAN	0	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
69.01	03610	SLEEP LAB	0	0	0	0	0	69.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
71.01	07101	IV SOLUTIONS	0	0	0	0	0	71.01	
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	03140	CARDIOLOGY	0	0	0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS									
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	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	162,901	0	162,901	95.00	
200.00		Total (Lines 50-199)	0	0	162,901	0	162,901	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/22/2017 11:00 am
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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)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	27,140,154	0.000000	0.000000	3,226,840	50.00
51.00	05100 RECOVERY ROOM	0	5,567,072	0.000000	0.000000	604,181	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,918,586	0.000000	0.000000	7,146	52.00
53.00	05300 ANESTHESIOLOGY	0	5,459,661	0.000000	0.000000	673,918	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	6,841,924	0.000000	0.000000	810,217	54.00
54.01	03630 ULTRA SOUND	162,901	1,767,402	0.092170	0.092170	98,440	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	5,190,252	0.000000	0.000000	227,768	54.02
55.00	03480 ONCOLOGY	0	5,101,654	0.000000	0.000000	80,776	55.00
57.00	05700 CT SCAN	0	14,401,773	0.000000	0.000000	1,348,241	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	4,457,809	0.000000	0.000000	118,665	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	2,505,427	0.000000	0.000000	353,530	59.00
60.00	06000 LABORATORY	0	25,953,293	0.000000	0.000000	2,881,350	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,737,189	0.000000	0.000000	267,095	62.00
65.00	06500 RESPIRATORY THERAPY	0	5,717,008	0.000000	0.000000	2,827,805	65.00
66.00	06600 PHYSICAL THERAPY	0	11,746,480	0.000000	0.000000	815,518	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01	03610 SLEEP LAB	0	1,761,739	0.000000	0.000000	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,493,336	0.000000	0.000000	2,606,777	71.00
71.01	07101 IV SOLUTIONS	0	2,480,615	0.000000	0.000000	573,469	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	17,172,490	0.000000	0.000000	6,365,344	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	51,051,829	0.000000	0.000000	12,208,338	73.00
76.00	03140 RADIOLOGY	0	9,340,168	0.000000	0.000000	1,164,359	76.00
76.97	07697 CARDIAC REHABILITATION	0	630,743	0.000000	0.000000	1,242	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	119,128	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	23,048,083	0.000000	0.000000	2,035,784	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,703,123	0.000000	0.000000	374,637	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	162,901	245,306,938			39,671,440	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/22/2017 11:00 am
Title XVIII		Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
ANCILLARY SERVICE COST CENTERS		11.00	12.00	13.00	
50.00	05000 OPERATING ROOM	0	6,703,720	0	50.00
51.00	05100 RECOVERY ROOM	0	921,616	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	901,332	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,514,633	0	54.00
54.01	03630 ULTRA SOUND	9,073	341,768	31,501	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	2,188,337	0	54.02
55.00	03480 ONCOLOGY	0	2,376,243	0	55.00
57.00	05700 CT SCAN	0	4,020,845	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,364,569	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	993,816	0	59.00
60.00	06000 LABORATORY	0	2,612,918	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	145,559	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	416,008	0	65.00
66.00	06600 PHYSICAL THERAPY	0	34,646	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	03610 SLEEP LAB	0	746,586	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,094,061	0	71.00
71.01	07101 IV SOLUTIONS	0	276,962	0	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,274,032	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	9,040,232	0	73.00
76.00	03140 CARDIOLOGY	0	3,393,317	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	245,642	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	10,964	0	90.00
91.00	09100 EMERGENCY	0	4,453,254	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	655,011	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	9,073	45,726,071	31,501	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/22/2017 11:00 am
		Title XVIII	Hospital	PPS

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	0.188665	6,703,720	0	0	1,264,757	50.00
51.00	05100	RECOVERY ROOM	0.097028	921,616	0	0	89,423	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.339958	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.060865	901,332	0	0	54,860	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.517814	1,514,633	0	0	784,298	54.00
54.01	03630	ULTRA SOUND	0.234974	341,768	0	0	80,307	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.082228	2,188,337	0	0	179,943	54.02
55.00	03480	ONCOLOGY	0.523696	2,376,243	4	2	1,244,429	55.00
57.00	05700	CT SCAN	0.053616	4,020,845	0	0	215,582	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.105001	1,364,569	0	0	143,281	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.155604	993,816	0	0	154,642	59.00
60.00	06000	LABORATORY	0.235947	2,612,918	648	0	616,510	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.188760	145,559	11	0	27,476	62.00
65.00	06500	RESPIRATORY THERAPY	0.182428	416,008	0	0	75,892	65.00
66.00	06600	PHYSICAL THERAPY	0.316838	34,646	0	0	10,977	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03610	SLEEP LAB	0.202613	746,586	0	0	151,268	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.347854	1,094,061	0	0	380,573	71.00
71.01	07101	IV SOLUTIONS	0.052869	276,962	0	0	14,643	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.300055	1,274,032	0	0	382,280	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153559	9,040,232	0	35,785	1,388,209	73.00
76.00	03140	CARDIOLOGY	0.133441	3,393,317	0	0	452,808	76.00
76.97	07697	CARDIAC REHABILITATION	0.280688	245,642	0	0	68,949	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2.159753	10,964	0	0	23,680	90.00
91.00	09100	EMERGENCY	0.158455	4,453,254	0	69	705,640	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.042383	655,011	0	0	682,772	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.649865		0			95.00
200.00		Subtotal (see instructions)		45,726,071	663	35,856	9,193,199	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		45,726,071	663	35,856	9,193,199	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/22/2017 11:00 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	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
51.00	05100 RECOVERY ROOM	0	0	51.00
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
54.01	03630 ULTRA SOUND	0	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	54.02
55.00	03480 ONCOLOGY	2	1	55.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	153	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
69.01	03610 SLEEP LAB	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
71.01	07101 IV SOLUTIONS	0	0	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5,495	73.00
76.00	03140 RADIOLOGY	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	11	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0		95.00
200.00	Subtotal (see instructions)	157	5,507	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	157	5,507	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/22/2017 11:00 am
		Title XIX	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	0.188665	0	0	4,597,392	0 50.00
51.00 05100 RECOVERY ROOM	0.097028	0	0	868,550	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.339958	0	0	2,662	0 52.00
53.00 05300 ANESTHESIOLOGY	0.060865	0	0	819,955	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.517814	0	0	1,229,953	0 54.00
54.01 03630 ULTRA SOUND	0.234974	0	0	429,036	0 54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.082228	0	0	508,414	0 54.02
55.00 03480 ONCOLOGY	0.523696	0	0	401,523	0 55.00
57.00 05700 CT SCAN	0.053616	0	0	2,278,719	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.105001	0	0	716,698	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0.155604	0	0	270,537	0 59.00
60.00 06000 LABORATORY	0.235947	0	0	4,350,859	0 60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.188760	0	0	93,439	0 62.00
65.00 06500 RESPIRATORY THERAPY	0.182428	0	0	333,485	0 65.00
66.00 06600 PHYSICAL THERAPY	0.316838	0	0	1,456,224	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0 69.00
69.01 03610 SLEEP LAB	0.202613	0	0	306,584	0 69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.347854	0	0	56,759	0 71.00
71.01 07101 IV SOLUTIONS	0.052869	0	0	221,860	0 71.01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.300055	0	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.153559	0	0	2,892,422	0 73.00
76.00 03140 RADIOLOGY	0.133441	0	0	936,216	0 76.00
76.97 07697 CARDIAC REHABILITATION	0.280688	0	0	16,200	0 76.97
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	2.159753	0	0	14,038	0 90.00
91.00 09100 EMERGENCY	0.158455	0	0	6,977,441	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.042383	0	0	1,448,109	0 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0.649865	0	0		95.00
200.00	Subtotal (see instructions)	0	0	31,227,075	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	31,227,075	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/22/2017 11:00 am
		Title XIX	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	0	867,367	50.00
51.00	05100	RECOVERY ROOM	0	84,274	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	905	52.00
53.00	05300	ANESTHESIOLOGY	0	49,907	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	636,887	54.00
54.01	03630	ULTRA SOUND	0	100,812	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	41,806	54.02
55.00	03480	ONCOLOGY	0	210,276	55.00
57.00	05700	CT SCAN	0	122,176	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	75,254	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	42,097	59.00
60.00	06000	LABORATORY	0	1,026,572	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	17,638	62.00
65.00	06500	RESPIRATORY THERAPY	0	60,837	65.00
66.00	06600	PHYSICAL THERAPY	0	461,387	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	03610	SLEEP LAB	0	62,118	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19,744	71.00
71.01	07101	IV SOLUTIONS	0	11,730	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	444,157	73.00
76.00	03140	CARDIOLOGY	0	124,930	76.00
76.97	07697	CARDIAC REHABILITATION	0	4,547	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	30,319	90.00
91.00	09100	EMERGENCY	0	1,105,610	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,509,484	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	7,110,834	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	7,110,834	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/22/2017 11:00 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		13,703	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		13,703	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)		10,470	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		5,548	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	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)		11,942,719	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		11,942,719	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)		11,942,719	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)		871.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,835,304	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)		4,835,304	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/22/2017 11:00 am	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	1,634,424	1,289	1,267.98	773	980,149	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)					8,456,277	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					14,271,730	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)					1,193,090	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					751,212	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,944,302	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					12,327,428	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)					3,233	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					871.54	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,817,689	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0069		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/22/2017 11:00 am	
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	2,720,327	11,942,719	0.227781	2,817,689	641,816	90.00
91.00	Nursing School cost	0	11,942,719	0.000000	2,817,689	0	91.00
92.00	Allied health cost	0	11,942,719	0.000000	2,817,689	0	92.00
93.00	All other Medical Education	0	11,942,719	0.000000	2,817,689	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/22/2017 11:00 am
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)		13,703	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		13,703	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)		10,470	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,688	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		1,135	15.00
16.00	Nursery days (title V or XIX only)		332	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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	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)		11,942,719	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		11,942,719	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)		11,942,719	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)		871.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,471,160	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)		1,471,160	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/22/2017 11:00 am	
Title XIX			Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	591,424	1,135	521.08	332	172,999	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	1,634,424	1,289	1,267.98	162	205,413	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,099,958	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,949,530	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)						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)					3,233	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					871.54	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,817,689	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0069		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/22/2017 11:00 am	
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	2,720,327	11,942,719	0.227781	2,817,689	641,816	90.00
91.00	Nursing School cost	0	11,942,719	0.000000	2,817,689	0	91.00
92.00	Allied health cost	0	11,942,719	0.000000	2,817,689	0	92.00
93.00	All other Medical Education	0	11,942,719	0.000000	2,817,689	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/22/2017 11:00 am	
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		6,242,979	30.00
31.00	03100	INTENSIVE CARE UNIT		1,465,843	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.188665	3,226,840	50.00
51.00	05100	RECOVERY ROOM	0.097028	604,181	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.339958	7,146	52.00
53.00	05300	ANESTHESIOLOGY	0.060865	673,918	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.517814	810,217	54.00
54.01	03630	ULTRA SOUND	0.234974	98,440	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.082228	227,768	54.02
55.00	03480	ONCOLOGY	0.523696	80,776	55.00
57.00	05700	CT SCAN	0.053616	1,348,241	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.105001	118,665	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.155604	353,530	59.00
60.00	06000	LABORATORY	0.238330	2,881,350	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.188760	267,095	62.00
65.00	06500	RESPIRATORY THERAPY	0.182428	2,827,805	65.00
66.00	06600	PHYSICAL THERAPY	0.316838	815,518	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
69.01	03610	SLEEP LAB	0.202613	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.347854	2,606,777	71.00
71.01	07101	IV SOLUTIONS	0.052869	573,469	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.300055	6,365,344	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153559	12,208,338	73.00
76.00	03140	CARDIOLOGY	0.133441	1,164,359	76.00
76.97	07697	CARDIAC REHABILITATION	0.280688	1,242	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2.159753	0	90.00
91.00	09100	EMERGENCY	0.158455	2,035,784	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.042383	374,637	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		39,671,440	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)		39,671,440	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/22/2017 11:00 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		2,576,917	30.00
31.00	03100	INTENSIVE CARE UNIT		265,417	31.00
43.00	04300	NURSERY		872,734	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.188665	2,280,641	430,277 50.00
51.00	05100	RECOVERY ROOM	0.097028	314,764	30,541 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.339958	1,062,349	361,154 52.00
53.00	05300	ANESTHESIOLOGY	0.060865	304,146	18,512 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.517814	151,762	78,584 54.00
54.01	03630	ULTRA SOUND	0.234974	58,398	13,722 54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.082228	45,686	3,757 54.02
55.00	03480	ONCOLOGY	0.523696	11,879	6,221 55.00
57.00	05700	CT SCAN	0.053616	335,991	18,014 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.105001	39,861	4,185 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.155604	34,501	5,368 59.00
60.00	06000	LABORATORY	0.235947	891,533	210,355 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.188760	111,395	21,027 62.00
65.00	06500	RESPIRATORY THERAPY	0.182428	590,161	107,662 65.00
66.00	06600	PHYSICAL THERAPY	0.316838	100,539	31,855 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0 69.00
69.01	03610	SLEEP LAB	0.202613	0	0 69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.347854	127,086	44,207 71.00
71.01	07101	IV SOLUTIONS	0.052869	250,017	13,218 71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.300055	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153559	3,888,644	597,136 73.00
76.00	03140	CARDIOLOGY	0.133441	175,790	23,458 76.00
76.97	07697	CARDIAC REHABILITATION	0.280688	0	0 76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2.159753	0	0 90.00
91.00	09100	EMERGENCY	0.158455	509,323	80,705 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.042383	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			
200.00		Total (sum of lines 50-94 and 96-98)		11,284,466	2,099,958 200.00
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)		11,284,466	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/22/2017 11:00 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		8,337,702	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,966,679	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		56,040	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		71.96	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.28	30.00
31.00	Percentage of Medicaid patient days (see instructions)		23.35	31.00
32.00	Sum of lines 30 and 31		28.63	32.00
33.00	Allowable disproportionate share percentage (see instructions)		13.07	33.00
34.00	Disproportionate share adjustment (see instructions)		369,371	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/22/2017 11:00 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000087360	0.000081381	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	559,643	486,454	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	418,968	122,613	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	541,581		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	46.00
47.00	Subtotal (see instructions)	12,271,373		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	12,381,131		48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		12,381,131	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		929,734	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		14,522	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		9,073	58.00
59.00	Total (sum of amounts on lines 49 through 58)		13,334,460	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		13,334,460	61.00
62.00	Deductibles billed to program beneficiaries		1,484,756	62.00
63.00	Coinurance billed to program beneficiaries		2,254	63.00
64.00	Allowable bad debts (see instructions)		157,192	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		102,175	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		71,316	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		11,949,625	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		61,062	70.93
70.94	HRR adjustment amount (see instructions)		-152,935	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/22/2017 11:00 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,857,752		71.00
71.01	Sequestration adjustment (see instructions)		237,155		71.01
72.00	Interim payments		11,882,394		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		-261,797		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		655,395		75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0		100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0		102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0		104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0069

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/22/2017 11:00 am

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	8,337,702	0	8,337,702		8,337,702	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,966,679	0		2,966,679	2,966,679	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	56,040	0	50,560	5,480	56,040	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1307	0.1307	0.1307	0.1307		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	369,371	0	272,435	96,936	369,371	11.00
11.01	Uncompensated care payments	36.00	541,581	0	418,968	122,613	541,581	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	12,271,373	0	9,079,665	3,191,708	12,271,373	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	12,381,131	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	12,381,131	0	9,189,423	3,191,708	12,381,131	15.00
16.00	Payment for inpatient program capital	50.00	929,734	0	688,089	241,645	929,734	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0069

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/22/2017 11:00 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	9,877,512	3,433,353	13,310,865	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	907,502	0	668,385	239,117	907,502	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	22,232	0	19,704	2,528	22,232	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	929,734	0	688,089	241,645	929,734	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/22/2017 11:00 am
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		Title XVIII			Hospital	PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	8,337,702	8,337,702		8,337,702	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,966,679		2,966,679	2,966,679	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	56,040	50,560	5,480	56,040	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1307	0.1307	0.1307		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	369,371	272,435	96,936	369,371	11.00
11.01	Uncompensated care payments	36.00	541,581	418,968	122,613	541,581	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	12,271,373	9,079,665	3,191,708	12,271,373	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	12,381,131	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	12,381,131	9,189,423	3,191,708	12,381,131	15.00
16.00	Payment for inpatient program capital	50.00	929,734	688,089	241,645	929,734	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			9,877,512	3,433,353	13,310,865	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/22/2017 11:00 am
		Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	907,502	668,385	239,117	907,502	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	22,232	19,704	2,528	22,232	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	929,734	688,089	241,645	929,734	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	61,062	35,045	26,017	61,062	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-152,935	-72,538	-80,397	-152,935	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/22/2017 11:00 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,664	1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)		9,161,698	2.00
3.00	PPS payments		9,990,975	3.00
4.00	Outlier payment (see instructions)		18,699	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		31,501	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,664	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		36,519	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)		36,519	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)		36,519	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		30,855	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		5,664	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)		10,041,175	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,116,818	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)		7,930,021	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)		7,930,021	30.00
31.00	Primary payer payments		1,084	31.00
32.00	Subtotal (line 30 minus line 31)		7,928,937	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)		390,757	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		253,992	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		302,157	36.00
37.00	Subtotal (see instructions)		8,182,929	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-4	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)		8,182,933	40.00
40.01	Sequestration adjustment (see instructions)		163,659	40.01
41.00	Interim payments		8,022,728	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-3,454	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: 15-0069		Period: From 01/01/2016 To 12/31/2016		Worksheet E-1 Part I Date/Time Prepared: 5/22/2017 11:00 am	
		Title XVIII		Hospital		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		11,882,394		8,022,728	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)		11,882,394		8,022,728	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		261,797		3,454	6.02	
7.00	Total Medicare program liability (see instructions)		11,620,597		8,019,274	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: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/22/2017 11:00 am
		Title XVIII	Hospital	PPS
				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		3,228	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		6,321	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		511	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		11,759	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		269,248,546	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		1,031,386	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)		352,224	8.00
9.00	Sequestration adjustment amount (see instructions)		7,044	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		345,180	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		394,812	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)		-49,632	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 5/22/2017 11:00 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		3,949,530		1.00
2.00	Medical and other services			7,110,834	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		3,949,530	7,110,834	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)		3,949,530	7,110,834	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		11,284,466	31,227,075	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)		11,284,466	31,227,075	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)		11,284,466	31,227,075	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		7,334,936	24,116,241	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)		3,949,530	7,110,834	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	0	24.00
25.00	Capital exception payments (see instructions)		0	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)		3,949,530	7,110,834	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)		3,949,530	7,110,834	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		3,949,530	7,110,834	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		3,949,530	7,110,834	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		3,949,530	7,110,834	40.00
41.00	Interim payments		3,949,530	7,110,834	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 15-0069

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

Worksheet G

Date/Time Prepared:
5/22/2017 11:00 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	20,980,469	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	12,121,632	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,464,740	0	0	0	7.00
8.00	Prepaid expenses	1,953,950	0	0	0	8.00
9.00	Other current assets	222,063	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)	37,742,854	0	0	0	11.00
FIXED ASSETS						
12.00	Land	4,937,784	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	119,255,880	0	0	0	15.00
16.00	Accumulated depreciation	-27,275,688	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	1,226,663	0	0	0	21.00
22.00	Accumulated depreciation	-1,092,466	0	0	0	22.00
23.00	Major movable equipment	63,148,477	0	0	0	23.00
24.00	Accumulated depreciation	-44,650,189	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)	115,550,461	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	103,743,392	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	103,743,392	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	257,036,707	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,914,818	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	11,084,593	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,999,411	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	93,823,589	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,358,046	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	95,181,635	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	108,181,046	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	148,855,661				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	148,855,661	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	257,036,707	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0069

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

Worksheet G-1

Date/Time Prepared:
5/22/2017 11:00 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		138,332,636		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		10,523,025				2.00
3.00	Total (sum of line 1 and line 2)		148,855,661		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)		148,855,661		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)		148,855,661		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: 15-0069

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	18,642,046		18,642,046	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)	18,642,046		18,642,046	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,733,934		2,733,934	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)	2,733,934		2,733,934	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	21,375,980		21,375,980	17.00
18.00	Ancillary services	70,379,776	153,789,938	224,169,714	18.00
19.00	Outpatient services	3,547,414	24,057,415	27,604,829	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,059,580	2,059,580	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	452,548	452,548	26.00
27.00	PRO FEES	2,917	84,573,029	84,575,946	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	95,306,087	264,932,510	360,238,597	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		122,691,768		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)		122,691,768		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0069

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

Worksheet G-3

Date/Time Prepared:
5/22/2017 11:00 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	360,238,597	1.00
2.00	Less contractual allowances and discounts on patients' accounts	234,933,352	2.00
3.00	Net patient revenues (line 1 minus line 2)	125,305,245	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	122,691,768	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,613,477	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	342,240	6.00
7.00	Income from investments	2,116,943	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	318,793	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	140,463	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	69,708	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER NONPATIENT REVENUE	344,742	24.00
24.01	GAIN/LOSS ON SALE	268,034	24.01
24.02	OTHER NONPATIENT OP REVENUE	1,361,900	24.02
25.00	Total other income (sum of lines 6-24)	4,962,823	25.00
26.00	Total (line 5 plus line 25)	7,576,300	26.00
27.00	GAIN/LOSS ON SALE	-2,946,725	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-2,946,725	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	10,523,025	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0069

Period: From 01/01/2016

Worksheet H

HHA CCN: 15-7141

To 12/31/2016

Date/Time Prepared: 5/22/2017 11:00 am

Home Health Agency I

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	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 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	265,431	0	0	10,494	275,925	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	344,857	0	37,225	0	382,082	6.00
7.00	Physical Therapy	186,924	0	21,460	0	208,384	7.00
8.00	Occupational Therapy	53,588	0	5,492	0	59,080	8.00
9.00	Speech Pathology	1,060	0	70	0	1,130	9.00
10.00	Medical Social Services	0	0	176	0	176	10.00
11.00	Home Health Aide	37,899	0	11,847	0	49,746	11.00
12.00	Supplies (see instructions)	0	0	0	288	288	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)	889,759	0	76,270	10,782	976,811	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	0	275,925	0	275,925		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	382,082	0	382,082		6.00
7.00	Physical Therapy	0	208,384	0	208,384		7.00
8.00	Occupational Therapy	0	59,080	0	59,080		8.00
9.00	Speech Pathology	0	1,130	0	1,130		9.00
10.00	Medical Social Services	197	373	0	373		10.00
11.00	Home Health Aide	0	49,746	0	49,746		11.00
12.00	Supplies (see instructions)	0	288	0	288		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)	197	977,008	0	977,008		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: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet H-1 Part I Date/Time Prepared: 5/22/2017 11:00 am			
		HHA CCN: 15-7141	Home Health Agency I	PPS			
	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (col s. 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	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	275,925	0	0	0	275,925	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	382,082	0	0	0	382,082	6.00
7.00	Physical Therapy	208,384	0	0	0	208,384	7.00
8.00	Occupational Therapy	59,080	0	0	0	59,080	8.00
9.00	Speech Pathology	1,130	0	0	0	1,130	9.00
10.00	Medical Social Services	373	0	0	0	373	10.00
11.00	Home Health Aide	49,746	0	0	0	49,746	11.00
12.00	Supplies (see instructions)	288	0	0	0	288	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)	977,008	0	0	0	977,008	24.00
		Administrative & General	Total (col s. 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	275,925					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	150,375	532,457				6.00
7.00	Physical Therapy	82,014	290,398				7.00
8.00	Occupational Therapy	23,252	82,332				8.00
9.00	Speech Pathology	445	1,575				9.00
10.00	Medical Social Services	147	520				10.00
11.00	Home Health Aide	19,579	69,325				11.00
12.00	Supplies (see instructions)	113	401				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)		977,008				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-0069

Period: From 01/01/2016

Worksheet H-1

HHA CCN: 15-7141

To 12/31/2016

Part II
Date/Time Prepared:
5/22/2017 11:00 am

Home Health
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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	-275,925	701,083
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	382,082
7.00	Physical Therapy	0	0	0	0	0	208,384
8.00	Occupational Therapy	0	0	0	0	0	59,080
9.00	Speech Pathology	0	0	0	0	0	1,130
10.00	Medical Social Services	0	0	0	0	0	373
11.00	Home Health Aide	0	0	0	0	0	49,746
12.00	Supplies (see instructions)	0	0	0	0	0	288
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	-275,925	701,083
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		275,925
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.393570

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 15-0069	Period: From 01/01/2016	Worksheet H-2 Part I
		HHA CCN: 15-7141	To 12/31/2016	Date/Time Prepared: 5/22/2017 11:00 am
			Home Health Agency I	PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP			
		0	1.00	1.01			
1.00 Administrative and General	0	0	22,559	0	55,882	78,441	1.00
2.00 Skilled Nursing Care	532,457	0	0	0	72,604	605,061	2.00
3.00 Physical Therapy	290,398	0	0	0	39,354	329,752	3.00
4.00 Occupational Therapy	82,332	0	0	0	11,282	93,614	4.00
5.00 Speech Pathology	1,575	0	0	0	223	1,798	5.00
6.00 Medical Social Services	520	0	0	0	41	561	6.00
7.00 Home Health Aide	69,325	0	0	0	7,979	77,304	7.00
8.00 Supplies (see instructions)	401	0	0	0	0	401	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)	977,008	0	22,559	0	187,365	1,186,932	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	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
	5.00	7.00	8.00	9.00	10.00	11.00	
1.00 Administrative and General	14,576	58,702	0	0	0	0	1.00
2.00 Skilled Nursing Care	112,434	0	0	0	0	0	2.00
3.00 Physical Therapy	61,276	0	0	0	0	0	3.00
4.00 Occupational Therapy	17,396	0	0	0	0	0	4.00
5.00 Speech Pathology	334	0	0	0	0	0	5.00
6.00 Medical Social Services	104	0	0	0	0	0	6.00
7.00 Home Health Aide	14,365	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	75	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)	220,560	58,702	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: 15-0069 HHA CCN: 15-7141		Period: From 01/01/2016 To 12/31/2016		Worksheet H-2 Part I Date/Time Prepared: 5/22/2017 11:00 am		
Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
		13.00	14.00	15.00	16.00	17.00	19.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	2,975	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	2,975	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
Cost Center Description	RADIOLOGY SCHOOL	HUB SITE - 3RD YEAR MED STUDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)		
	23.00	23.01	24.00	25.00	26.00	27.00		
1.00	Administrative and General	0	0	151,719	0	151,719	0	1.00
2.00	Skilled Nursing Care	0	0	717,495	0	717,495	82,627	2.00
3.00	Physical Therapy	0	0	391,028	0	391,028	45,031	3.00
4.00	Occupational Therapy	0	0	111,010	0	111,010	12,784	4.00
5.00	Speech Pathology	0	0	2,132	0	2,132	246	5.00
6.00	Medical Social Services	0	0	665	0	665	77	6.00
7.00	Home Health Aide	0	0	91,669	0	91,669	10,557	7.00
8.00	Supplies (see instructions)	0	0	3,451	0	3,451	397	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	1,469,169	0	1,469,169	151,719	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.						0.115161	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: 15-0069

Period: From 01/01/2016

Worksheet H-2

HHA CCN: 15-7141

To 12/31/2016

Part I
Date/Time Prepared:
5/22/2017 11:00 am

Home Health
Agency I

PPS

Cost Center Description		Total HHA Costs		
		28.00		
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	800,122		2.00
3.00	Physical Therapy	436,059		3.00
4.00	Occupational Therapy	123,794		4.00
5.00	Speech Pathology	2,378		5.00
6.00	Medical Social Services	742		6.00
7.00	Home Health Aide	102,226		7.00
8.00	Supplies (see instructions)	3,848		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)	1,469,169		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: 15-0069 HHA CCN: 15-7141	Period: From 01/01/2016 To 12/31/2016	Worksheet H-2 Part II Date/Time Prepared: 5/22/2017 11:00 am
		Home Health Agency I	PPS

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW BLDG & FIXT HHA/HO (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	1.01	2.00				
1.00 Administrative and General	0	2,748	2,748	265,431	0	78,441	1.00
2.00 Skilled Nursing Care	0	0	0	344,858	0	605,061	2.00
3.00 Physical Therapy	0	0	0	186,924	0	329,752	3.00
4.00 Occupational Therapy	0	0	0	53,588	0	93,614	4.00
5.00 Speech Pathology	0	0	0	1,060	0	1,798	5.00
6.00 Medical Social Services	0	0	0	197	0	561	6.00
7.00 Home Health Aide	0	0	0	37,899	0	77,304	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	401	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	2,748	2,748	889,957		1,186,932	20.00
21.00 Total cost to be allocated	0	22,559	0	187,365		220,560	21.00
22.00 Unit cost multiplier	0.000000	8.209243	0.000000	0.210533		0.185824	22.00

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATIVE (DIRECT NRSING HRS)	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	2,748	0	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	2,748	0	0	0	0	0	20.00
21.00 Total cost to be allocated	58,702	0	0	0	0	0	21.00
22.00 Unit cost multiplier	21.361718	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 15-0069 HHA CCN: 15-7141	Period: From 01/01/2016 To 12/31/2016	Worksheet H-2 Part II Date/Time Prepared: 5/22/2017 11:00 am
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Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	RADIOLOGY SCHOOL (ASSIGNED TIME)	
		14.00	15.00	16.00	17.00	19.00	23.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	1,877	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	Telmedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,877	0	0	0	0	0	20.00
21.00	Total cost to be allocated	2,975	0	0	0	0	0	21.00
22.00	Unit cost multiplier	1.584976	0.000000	0.000000	0.000000	0.000000	0.000000	22.00
Cost Center Description		HUB SITE - 3RD YEAR MED STUDENTS (ASSIGNED TIME)						
		23.01						
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	Telmedicine	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: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet H-3 Part I Date/Time Prepared: 5/22/2017 11:00 am
		HHA CCN: 15-7141		

			Title XVIII	Home Health Agency I	PPS	
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	800,122		800,122	4,514	177.25	1.00
2.00	Physical Therapy	3.00	436,059	0	436,059	2,881	151.36	2.00
3.00	Occupational Therapy	4.00	123,794	0	123,794	640	193.43	3.00
4.00	Speech Pathology	5.00	2,378	0	2,378	15	158.53	4.00
5.00	Medical Social Services	6.00	742		742	1	742.00	5.00
6.00	Home Health Aide	7.00	102,226		102,226	1,162	87.97	6.00
7.00	Total (sum of lines 1-6)		1,465,321	0	1,465,321	9,213		7.00

		Program Visits				
Cost Center Description	Cost Limits	CBSA No. (1)	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		50031	0	0		8.00
8.01	Skilled Nursing Care		50034	0	2,619		8.01
9.00	Physical Therapy		50031	0	0		9.00
9.01	Physical Therapy		50034	0	1,919		9.01
10.00	Occupational Therapy		50031	0	0		10.00
10.01	Occupational Therapy		50034	0	475		10.01
11.00	Speech Pathology		50031	0	0		11.00
11.01	Speech Pathology		50034	0	11		11.01
12.00	Medical Social Services		50031	0	0		12.00
12.01	Medical Social Services		50034	0	1		12.01
13.00	Home Health Aide		50031	0	0		13.00
13.01	Home Health Aide		50034	0	658		13.01
14.00	Total (sum of lines 8-13)			0	5,683		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	3,848	0	3,848	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

		Program Visits			Cost of Services	
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	10.00	11.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	2,619		0	464,218	1.00
2.00	Physical Therapy	0	1,919		0	290,460	2.00
3.00	Occupational Therapy	0	475		0	91,879	3.00
4.00	Speech Pathology	0	11		0	1,744	4.00
5.00	Medical Social Services	0	1		0	742	5.00
6.00	Home Health Aide	0	658		0	57,884	6.00
7.00	Total (sum of lines 1-6)	0	5,683		0	906,927	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0069

Period: From 01/01/2016

Worksheet H-3

HHA CCN: 15-7141

To 12/31/2016

Part I
Date/Time Prepared:
5/22/2017 11:00 am

Title XVIII

Home Health Agency I

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	0	15.00
16.00	Cost of Drugs		0	0			0	16.00
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	464,218						1.00
2.00	Physical Therapy	290,460						2.00
3.00	Occupational Therapy	91,879						3.00
4.00	Speech Pathology	1,744						4.00
5.00	Medical Social Services	742						5.00
6.00	Home Health Aide	57,884						6.00
7.00	Total (sum of lines 1-6)	906,927						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: 15-0069 HHA CCN: 15-7141	Period: From 01/01/2016 To 12/31/2016	Worksheet H-3 Part II Date/Time Prepared: 5/22/2017 11:00 am
		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	0.316838	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.000000	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.000000	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.347854	0	0	col. 2, line 15.00	4.00
4.01	Cost of Medical Supplies 1	71.01	0.052869	0	0	col. 2, line 15.01	4.01
5.00	Cost of Drugs	73.00	0.153559	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069 HHA CCN: 15-7141	Period: From 01/01/2016 To 12/31/2016	Worksheet H-4 Part I-II Date/Time Prepared: 5/22/2017 11:00 am
		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	813,463
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	28,569
13.00	Total PPS Reimbursement - LUPA Episodes		0	13,020
14.00	Total PPS Reimbursement - PEP Episodes		0	9,653
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	7,823
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	872,528
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	872,528
25.00	Coinurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	872,528
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	872,528
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	872,528
31.01	Sequestration adjustment (see instructions)		0	17,451
32.00	Interim payments (see instructions)		0	855,078
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: 15-0069	Period: From 01/01/2016	Worksheet H-5
	HHA CCN: 15-7141	To 12/31/2016	Date/Time Prepared: 5/22/2017 11:00 am

		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		855,078	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		855,078	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1	6.02
7.00	Total Medicare program liability (see instructions)		0		855,077	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: 15-0069

Period: From 01/01/2016

Worksheet 0

Hospice CCN: 15-1535

To 12/31/2016

Date/Time Prepared: 5/22/2017 11:00 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI - CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0
4.00	ADMINISTRATIVE & GENERAL*	11,203	3,630	14,833	0	14,833
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0
7.00	HOUSEKEEPING*	0	0	0	0	0
8.00	DIETARY*	0	0	0	0	0
9.00	NURSING ADMINISTRATION*	0	0	0	0	0
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0
11.00	MEDICAL RECORDS*	0	0	0	0	0
12.00	STAFF TRANSPORTATION*	0	435	435	0	435
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0
14.00	PHARMACY*	0	31,571	31,571	0	31,571
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0
16.00	OTHER GENERAL SERVICE (DELETED)*	0	0	0	0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES					
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**	0	0	0	0	0
26.00	PHYSICIAN SERVICES**	0	0	0	0	0
27.00	NURSE PRACTITIONER**	0	0	0	0	0
28.00	REGISTERED NURSE**	46,086	7,114	53,200	0	53,200
29.00	LPN/LVN**	0	0	0	0	0
30.00	PHYSICAL THERAPY**	2,420	1,834	4,254	0	4,254
31.00	OCCUPATIONAL THERAPY**	67	0	67	0	67
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0
33.00	MEDICAL SOCIAL SERVICES**	0	1,698	1,698	0	1,698
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0
35.00	DIETARY COUNSELING**	0	0	0	0	0
36.00	COUNSELING - OTHER**	0	0	0	0	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	8,666	2,697	11,363	-197	11,166
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	53,594	53,594	0	53,594
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0
40.00	IMAGING SERVICES**	0	0	0	0	0
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0
43.00	OUTPATIENT SERVICES**	0	0	0	0	0
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0
62.00	FUNDRAISING*	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0
66.00	RESIDENTIAL CARE*	0	0	0	0	0
67.00	ADVERTISING*	0	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0
69.00	THRIFT STORE*	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0
100.00	TOTAL	68,442	102,573	171,015	-197	170,818

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0069

Period: From 01/01/2016

Worksheet 0

Hospice CCN: 15-1535

To 12/31/2016

Date/Time Prepared: 5/22/2017 11:00 am

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	14,833	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	435	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	31,571	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	53,200	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	4,254	30.00
31.00	OCCUPATIONAL THERAPY**	0	67	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	1,698	33.00
34.00	SPIRITUAL COUNSELING**	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	11,166	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	53,594	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	42.00
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	170,818	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE	Provider CCN: 15-0069 Hospice CCN: 15-1535	Period: From 01/01/2016 To 12/31/2016	Worksheet 0-2 Date/Time Prepared: 5/22/2017 11:00 am
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	Hospice I					
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED					25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	45,648	7,046	52,694	0	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	2,397	1,817	4,214	0	30.00
31.00	OCCUPATIONAL THERAPY	66	0	66	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	1,682	1,682	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	8,584	2,671	11,255	-195	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	53,594	53,594	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	56,695	66,810	123,505	-195	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

	ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
	6.00	7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED		25.00
26.00	PHYSICIAN SERVICES	0	26.00
27.00	NURSE PRACTITIONER	0	27.00
28.00	REGISTERED NURSE	0	28.00
29.00	LPN/LVN	0	29.00
30.00	PHYSICAL THERAPY	0	30.00
31.00	OCCUPATIONAL THERAPY	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	33.00
34.00	SPIRITUAL COUNSELING	0	34.00
35.00	DIETARY COUNSELING	0	35.00
36.00	COUNSELING - OTHER	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	38.00
39.00	PATIENT TRANSPORTATION	0	39.00
40.00	IMAGING SERVICES	0	40.00
41.00	LABS & DIAGNOSTICS	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	42.00
43.00	OUTPATIENT SERVICES	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	46.00
100.00	TOTAL *	0	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL
INPATIENT CARE

Provider CCN: 15-0069
Hospice CCN: 15-1535

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

Worksheet 0-4
Date/Time Prepared:
5/22/2017 11:00 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	438	68	506	0	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	23	17	40	0	30.00
31.00	OCCUPATIONAL THERAPY	1	0	1	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	16	16	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	82	26	108	-2	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN					38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	544	127	671	-2	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)
		6.00	7.00
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0
26.00	PHYSICIAN SERVICES	0	0
27.00	NURSE PRACTITIONER	0	0
28.00	REGISTERED NURSE	0	506
29.00	LPN/LVN	0	0
30.00	PHYSICAL THERAPY	0	40
31.00	OCCUPATIONAL THERAPY	0	1
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0
33.00	MEDICAL SOCIAL SERVICES	0	16
34.00	SPIRITUAL COUNSELING	0	0
35.00	DIETARY COUNSELING	0	0
36.00	COUNSELING - OTHER	0	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	106
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN		
39.00	PATIENT TRANSPORTATION	0	0
40.00	IMAGING SERVICES	0	0
41.00	LABS & DIAGNOSTICS	0	0
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0
43.00	OUTPATIENT SERVICES	0	0
44.00	PALLIATIVE RADIATION THERAPY	0	0
45.00	PALLIATIVE CHEMOTHERAPY	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0
100.00	TOTAL *	0	669

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPI CE NET EXPENSES FOR ALLOCATION

Provider CCN: 15-0069

Period: From 01/01/2016

Worksheet 0-5

Hospice CCN: 15-1535

To 12/31/2016

Date/Time Prepared: 5/22/2017 11:00 am

Descriptions		Hospice I			
		HOSPI CE DI RECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of col s. 1 + 2)	
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	6,108	6,108	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	14,368	14,368	3.00
4.00	ADMINISTRATIVE & GENERAL	14,833	35,547	50,380	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	435	0	435	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	13.00
14.00	PHARMACY	31,571	0	31,571	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPI CE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPI CE ROUTINE HOME CARE	123,310	0	123,310	51.00
52.00	HOSPI CE INPATIENT RESPI TE CARE	0	0	0	52.00
53.00	HOSPI CE GENERAL INPATIENT CARE	669	0	669	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPI CE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	170,818	56,023	226,841	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 15-0069	Period: From 01/01/2016	Worksheet 0-6
		Hospice CCN: 15-1535	To 12/31/2016	Part I
				Date/Time Prepared: 5/22/2017 11:00 am

Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
	0	1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIX	6,108	6,108			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	14,368	0	0	14,368	3.00
4.00	ADMINISTRATIVE & GENERAL	50,380	6,108	0	2,359	58,847
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0
7.00	HOUSEKEEPING	0	0	0	0	0
8.00	DIETARY	0	0	0	0	0
9.00	NURSING ADMINISTRATION	0	0	0	0	0
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0
11.00	MEDICAL RECORDS	0	0	0	0	0
12.00	STAFF TRANSPORTATION	435	0	0	0	435
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0
14.00	PHARMACY	31,571	0	0	0	31,571
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0
51.00	HOSPICE ROUTINE HOME CARE	123,310			11,895	135,205
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0	0	0
53.00	HOSPICE GENERAL INPATIENT CARE	669	0	0	114	783
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0
61.00	VOLUNTEER PROGRAM	0	0	0	0	0
62.00	FUNDRAISING	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0
66.00	RESIDENTIAL CARE	0	0	0	0	0
67.00	ADVERTISING	0	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0
69.00	THRIFT STORE	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD	0				0
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0
99.00	NEGATIVE COST CENTER	0	0	0	0	0
100.00	TOTAL	226,841	6,108	0	14,368	226,841

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet 0-6 Part I
		Hospice CCN: 15-1535		Date/Time Prepared: 5/22/2017 11:00 am

Descriptions	Hospice I					
	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00	58,847					4.00
5.00	0	0				5.00
6.00	0	0	0			6.00
7.00	0	0		0		7.00
8.00	0	0		0	0	8.00
9.00	0	0		0		9.00
10.00	0	0		0		10.00
11.00	0	0		0		11.00
12.00	152	0		0		12.00
13.00	0	0		0		13.00
14.00	11,059	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
LEVEL OF CARE						
50.00	0					50.00
51.00	47,362					51.00
52.00	0	0	0	0	0	52.00
53.00	274	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS						
60.00	0	0		0		60.00
61.00	0	0		0		61.00
62.00	0	0		0		62.00
63.00	0	0		0		63.00
64.00	0	0		0		64.00
65.00	0	0		0		65.00
66.00	0	0	0	0	0	66.00
67.00	0	0		0		67.00
68.00	0	0		0		68.00
69.00	0	0		0		69.00
70.00						70.00
71.00	0	0	0	0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	58,847	0	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 15-0069	Period: From 01/01/2016	Worksheet 0-6
		Hospice CCN: 15-1535	To 12/31/2016	Part I
				Date/Time Prepared: 5/22/2017 11:00 am

Descriptions	Hospice I					
	NURSING ADMINISTRATIVE	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
	9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION	0				9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0			10.00
11.00	MEDICAL RECORDS	0		0		11.00
12.00	STAFF TRANSPORTATION	0			587	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	13.00
14.00	PHARMACY	0			0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0			0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0	581	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	6	53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	60.00
61.00	VOLUNTEER PROGRAM	0			0	61.00
62.00	FUNDRAISING	0			0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	65.00
66.00	RESIDENTIAL CARE	0			0	66.00
67.00	ADVERTISING	0			0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	68.00
69.00	THRIFT STORE	0			0	69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	99.00
100.00	TOTAL	0	0	0	587	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0069

Period: From 01/01/2016

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2016

Part I
Date/Time Prepared:
5/22/2017 11:00 am

Descriptions	Hospice I				TOTAL	
	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE (DELETED)	PATIENT/ RESIDENTIAL CARE SERVICES		
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00	42,630					14.00
15.00	0	0				15.00
16.00	0		0			16.00
17.00				0		17.00
LEVEL OF CARE						
50.00	0	0	0		0	50.00
51.00	42,226	0	0		225,374	51.00
52.00	0	0	0	0	0	52.00
53.00	404	0	0	0	1,467	53.00
NONREIMBURSABLE COST CENTERS						
60.00	0		0		0	60.00
61.00	0		0		0	61.00
62.00	0		0		0	62.00
63.00	0		0		0	63.00
64.00	0		0		0	64.00
65.00	0		0		0	65.00
66.00	0	0	0	0	0	66.00
67.00	0		0		0	67.00
68.00	0		0		0	68.00
69.00	0		0		0	69.00
70.00	0		0		0	70.00
71.00	0	0	0	0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	42,630	0	0	0	226,841	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPI CE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0069

Period: From 01/01/2016

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2016

Part II
Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Descriptions		Hospice I					
		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	744					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	68,246			3.00
4.00	ADMINISTRATIVE & GENERAL	744	0	11,203	-58,847	167,994	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	435	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	31,571	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			56,501	0	135,205	51.00
52.00	HOSPICE INPATIENT RESPI TE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	542	0	783	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	6,108	0	14,368		58,847	100.00
101.00	UNIT COST MULTIPLIER	8.209677	0.000000	0.210532		0.350292	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0069

Period: From 01/01/2016

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2016

Part II
Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0		0		0	99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPI CE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0069

Period: From 01/01/2016

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2016

Part II
Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Descriptions		Hospice I					
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	0					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			13,343			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	40,263	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	13,216	0	39,881	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	127	0	382	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	587	0	42,630	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.043993	0.000000	1.058788	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0069

Period: From 01/01/2016

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2016

Part II
Date/Time Prepared:
5/22/2017 11:00 am

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (DELETED) (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE (DELETED)		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER		0			99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		0			100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 15-0069

Period: From 01/01/2016

Worksheet 0-7

Hospice CCN: 15-1535

To 12/31/2016

Date/Time Prepared: 5/22/2017 11:00 am

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)				
				HCHC	HRHC	HIRC		
				0	1.00	2.00		3.00
ANCILLARY SERVICE COST CENTERS								
1.00	PHYSICAL THERAPY	66.00	0.316838	0	0	0	1.00	
2.00	OCCUPATIONAL THERAPY	67.00	0.000000	0	0	0	2.00	
3.00	SPEECH PATHOLOGY	68.00	0.000000	0	0	0	3.00	
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.153559	0	0	0	4.00	
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00	
6.00	LABORATORY	60.00	0.235947	0	0	0	6.00	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.347854	0	0	0	7.00	
7.01	IV SOLUTIONS	71.01	0.052869	0	0	0	7.01	
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00	
9.00	ONCOLOGY	55.00	0.523696	0	0	0	9.00	
10.00	CARDIOLOGY	76.00	0.133441	0	0	0	10.00	
10.97	CARDIAC REHABILITATION	76.97	0.280688	0	0	0	10.97	
11.00	Totals (sum of lines 1-11)						11.00	
Cost Center Descriptions		Charges by LOC (From Provider Records)	Shared Service Costs by LOC					
			HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)		HGIP (col. 1 x col. 5)
			5.00	6.00	7.00	8.00		9.00
ANCILLARY SERVICE COST CENTERS								
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00	
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00	
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00	
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00	
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00	
6.00	LABORATORY	0	0	0	0	0	6.00	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00	
7.01	IV SOLUTIONS	0	0	0	0	0	7.01	
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00	
9.00	ONCOLOGY	0	0	0	0	0	9.00	
10.00	CARDIOLOGY	0	0	0	0	0	10.00	
10.97	CARDIAC REHABILITATION	0	0	0	0	0	10.97	
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00	

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0069

Period: From 01/01/2016

Worksheet 0-8

Hospice CCN: 15-1535

To 12/31/2016

Date/Time Prepared: 5/22/2017 11:00 am

		Hospice I		
		TITLE XVII MEDI CARE	TITLE XIX MEDI CAID	TOTAL
		1.00	2.00	3.00
HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0
3.00	Total average cost per diem (line 1 divided by line 2)			0.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)			
5.00	Program cost (line 3 times line 4)	0	0	0
HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			225,374
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			2,087
8.00	Total average cost per diem (line 6 divided by line 7)			107.99
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	1,887	5	
10.00	Program cost (line 8 times line 9)	203,777	540	
HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			0
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			0
13.00	Total average cost per diem (line 11 divided by line 12)			0.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	0	0	
15.00	Program cost (line 13 times line 14)	0	0	
HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			1,467
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			20
18.00	Total average cost per diem (line 16 divided by line 17)			73.35
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	7	5	
20.00	Program cost (line 18 times line 19)	513	367	
TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			226,841
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			2,107
23.00	Average cost per diem (line 21 divided by line 22)			107.66

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0069	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/22/2017 11:00 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		907,502	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		22,232	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		33.11	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		929,734	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00