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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1305	Period: From 10/01/2015 To 09/30/2016	Worksheet S Parts I-III Date/Time Prepared: 4/21/2017 4:04 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 4/21/2017 Time: 4:04 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PULASKI MEMORIAL HOSPITAL (15-1305) for the cost reporting period beginning 10/01/2015 and ending 09/30/2016 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	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	58,863	169,822	0	40,930	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	25,579	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		47,515		0	10.00
200.00	Total	0	84,442	217,337	0	40,930	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1305	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 4/21/2017 3:37 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 616 EAST 13TH	PO Box:			1.00
2.00	City: WINAMAC	State: IN	Zip Code: 46996-	County: PULASKI	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PULASKI MEMORIAL HOSPITAL	151305	99915	1	10/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PULASKI MEMORIAL HOSPITAL	15Z305	99915		10/01/2000	N	O	P	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	PULASKI MEMORIAL HOSPITAL	157078	99915		10/14/1982	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	PULASKI MEMORIAL HOSPICE	151550	99915		09/01/1997				14.00
15.00	Hospital-Based Health Clinic - RHC	PULASKI MEMORIAL RHC	158512	99915		08/21/2014	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2015	09/30/2016	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.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 4/21/2017 3:37 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 4/21/2017 3:37 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	125,780	0	0	118.01

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		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 4/21/2017 3:37 pm

							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
						Beginning	Ending	
						1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					10/03/2016	12/31/2016	170.00
						1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 4/21/2017 3:37 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	02/09/2017	Y	02/09/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 4/21/2017 3:37 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL	ALESSANDRINI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.713.7959	MALESSANDRINI@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1305	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Prepared: 4/21/2017 3:37 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 4/21/2017 3:37 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	47,712.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	47,712.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,150	47,712.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 4/21/2017 3:37 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,100	44	1,988			1.00
2.00	HMO and other (see instructions)	76	221				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	957	0	970			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	162			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,057	44	3,120			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		12	188			13.00
14.00	Total (see instructions)	2,057	56	3,308	0.00	188.81	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,880	0	4,192	0.00	11.15	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.61	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	3,991	286	18,977	0.00	39.24	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	239.81	27.00
28.00	Observation Bed Days		0	290			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			18			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 4/21/2017 3:37 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	293	17	583	1.00
2.00	HMO and other (see instructions)			20	81		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	293	17	583	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-1305 | Component CCN: 15-7078 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-4 | Date/Time Prepared: 4/21/2017 3:37 pm

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	132.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.42	0.00	0.42	4.00
5.00	Other Administrative Personnel		0.02	0.00	0.02	5.00
6.00	Direct Nursing Service		4.13	0.00	4.13	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.60	0.00	0.60	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.14	0.00	0.14	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.05	0.00	0.05	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		3.39	0.00	3.39	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	OTHER		0.45	0.00	0.45	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.		3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		23844			20.00
20.01			50031			20.01
20.02			99915			20.02

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,046	93	58	4	1,201	21.00
22.00	Skilled Nursing Visit Charges	228,010	20,333	12,681	875	261,899	22.00
23.00	Physical Therapy Visits	630	21	6	6	663	23.00
24.00	Physical Therapy Visit Charges	149,773	5,009	1,431	1,431	157,644	24.00
25.00	Occupational Therapy Visits	131	18	2	4	155	25.00
26.00	Occupational Therapy Visit Charges	31,018	4,293	477	954	36,742	26.00
27.00	Speech Pathology Visits	55	0	2	0	57	27.00
28.00	Speech Pathology Visit Charges	13,118	0	477	0	13,595	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	731	66	7	0	804	31.00
32.00	Home Health Aide Visit Charges	73,612	6,660	706	0	80,978	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,593	198	75	14	2,880	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)	495,531	36,295	15,772	3,260	550,858	35.00
36.00	Total Number of Episodes (standard/non outlier)	162		29	1	192	36.00
37.00	Total Number of Outlier Episodes		4		0	4	37.00
38.00	Total Non-Routine Medical Supply Charges	34,743	3,469	2,310	0	40,522	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-8 | Date/Time Prepared: 4/21/2017 3:37 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			540 HOSPITAL DRIVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WINIMAC		IN	46996	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	Clinic			08:00	17:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		PULASKI				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	18:30	08:00	17:00	08:00	18:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

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

Period:
From 10/01/2015
To 09/30/2016

Worksheet S-8

Date/Time Prepared:
4/21/2017 3:37 pm

RHC I

Cost

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

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

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

Period: From 10/01/2015 To 09/30/2016

Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 4/21/2017 3:37 pm

Hospice I

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS 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	7	0	0	7	11.00
12.00	Hospice Inpatient Respite Care	0	0	0	0	12.00
13.00	Hospice General Inpatient Care	0	0	0	0	13.00
14.00	Total Hospice Days	7	0	0	7	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: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-10 | Date/Time Prepared: 4/21/2017 3:37 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.436704	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	754,054	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	294,789	5.00
6.00	Medicaid charges	4,202,680	6.00
7.00	Medicaid cost (line 1 times line 6)	1,835,327	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)	786,484	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)	786,484	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	396,501	0	396,501	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	173,154	0	173,154	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	173,154	0	173,154	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)	0	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	308,380	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	-308,380	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	-134,671	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	38,483	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	824,967	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 4/21/2017 3:37 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,301,907	1,301,907	24,844	1,326,751	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,088,922	5,088,922	0	5,088,922	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,980,636	1,928,200	3,908,836	327,347	4,236,183	5.00
7.00	00700	OPERATION OF PLANT	252,510	532,225	784,735	0	784,735	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,889	55,326	71,215	0	71,215	8.00
9.00	00900	HOUSEKEEPING	149,929	79,897	229,826	0	229,826	9.00
10.00	01000	DIETARY	174,492	176,943	351,435	0	351,435	10.00
13.00	01300	NURSING ADMINISTRATION	416,080	12,251	428,331	0	428,331	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	41,124	44,945	86,069	0	86,069	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	284,569	45,676	330,245	0	330,245	16.00
17.00	01700	SOCIAL SERVICE	50,806	127	50,933	0	50,933	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,836,640	138,688	1,975,328	75,873	2,051,201	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	65,488	5,443	70,931	0	70,931	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	541,540	109,533	651,073	275,869	926,942	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	87,925	6,353	94,278	0	94,278	52.00
53.00	05300	ANESTHESIOLOGY	0	606,206	606,206	0	606,206	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	736,970	861,822	1,598,792	0	1,598,792	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	564,308	710,954	1,275,262	0	1,275,262	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	66,508	66,508	0	66,508	63.00
65.00	06500	RESPIRATORY THERAPY	260,700	23,619	284,319	0	284,319	65.00
66.00	06600	PHYSICAL THERAPY	689,140	13,828	702,968	0	702,968	66.00
67.00	06700	OCCUPATIONAL THERAPY	94,420	957	95,377	0	95,377	67.00
68.00	06800	SPEECH PATHOLOGY	97,157	6,749	103,906	0	103,906	68.00
69.00	06900	ELECTROCARDIOLOGY	12,634	9,399	22,033	0	22,033	69.00
69.01	06901	CARDIAC REHABILITATION	61,732	1,950	63,682	0	63,682	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	611,837	611,837	-182,423	429,414	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	182,423	182,423	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,973,436	1,973,436	0	1,973,436	73.00
76.00	03020	ONCOLOGY	104,396	36,603	140,999	0	140,999	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,419,654	250,546	3,670,200	-648,390	3,021,810	88.00
90.00	09000	CLINIC	85,223	217,628	302,851	0	302,851	90.00
91.00	09100	EMERGENCY	892,790	923,012	1,815,802	0	1,815,802	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	567,696	98,267	665,963	-56,932	609,031	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	26,096	1,371	27,467	0	27,467	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,510,544	15,941,128	29,451,672	-1,389	29,450,283	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,094,399	740,228	1,834,627	36,663	1,871,290	192.00
194.00	07950	MARKETING	89,201	145,961	235,162	-35,274	199,888	194.00
200.00		TOTAL (SUM OF LINES 118-199)	14,694,144	16,827,317	31,521,461	0	31,521,461	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 4/21/2017 3:37 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-11,712	1,315,039		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,088,922		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-339,420	3,896,763		5.00
7.00	00700	OPERATION OF PLANT	-278	784,457		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	71,215		8.00
9.00	00900	HOUSEKEEPING	0	229,826		9.00
10.00	01000	DIETARY	-66,114	285,321		10.00
13.00	01300	NURSING ADMINISTRATION	0	428,331		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-29,532	56,537		14.00
15.00	01500	PHARMACY	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,667	323,578		16.00
17.00	01700	SOCIAL SERVICE	0	50,933		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-385,912	1,665,289		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	70,931		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-275,869	651,073		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	94,278		52.00
53.00	05300	ANESTHESIOLOGY	-589,327	16,879		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,598,792		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	1,275,262		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	66,508		63.00
65.00	06500	RESPIRATORY THERAPY	-1,000	283,319		65.00
66.00	06600	PHYSICAL THERAPY	0	702,968		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	95,377		67.00
68.00	06800	SPEECH PATHOLOGY	0	103,906		68.00
69.00	06900	ELECTROCARDIOLOGY	-4,225	17,808		69.00
69.01	06901	CARDIAC REHABILITATION	0	63,682		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-551	428,863		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	182,423		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-108,550	1,864,886		73.00
76.00	03020	ONCOLOGY	0	140,999		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	3,021,810		88.00
90.00	09000	CLINIC	0	302,851		90.00
91.00	09100	EMERGENCY	0	1,815,802		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	609,031		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	27,467		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,819,157	27,631,126		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	HOMECARE	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,871,290		192.00
194.00	07950	MARKETING	0	199,888		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-1,819,157	29,702,304		200.00

RECLASSIFICATIONS | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 4/21/2017 3:37 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - PROPERTY INSURANCE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	24,844	1.00
	0		0	24,844	
	B - MARKETING RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	13,380	21,894	1.00
	0		13,380	21,894	
	C - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	182,423	1.00
	0		0	182,423	
	D - PHYSICIAN SALARIES				
1.00	ADULTS & PEDIATRICS	30.00	75,873	0	1.00
2.00	OPERATING ROOM	50.00	275,869	0	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	36,663	0	3.00
	0		388,405	0	
	E - RHC PHYSICIAN COSTS				
1.00	RURAL HEALTH CLINIC	88.00	0	15,553	1.00
	TOTALS		0	15,553	
	F - BILLER RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	56,932	0	1.00
	TOTALS		56,932	0	
	G - PATIENT ACCOUNTS RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	275,538	0	1.00
	TOTALS		275,538	0	
500.00	Grand Total: Increases		734,255	244,714	500.00

RECLASSIFICATIONS | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 4/21/2017 3:37 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	24,844	12		1.00
	0		0	24,844			
	B - MARKETING RECLASS						
1.00	MARKETING	194.00	13,380	21,894	0		1.00
	0		13,380	21,894			
	C - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	182,423	0		1.00
	0		0	182,423			
	D - PHYSICIAN SALARIES						
1.00	RURAL HEALTH CLINIC	88.00	388,405	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		388,405	0			
	E - RHC PHYSICIAN COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,553	0		1.00
	TOTALS		0	15,553			
	F - BILLER RECLASS						
1.00	HOME HEALTH AGENCY	101.00	56,932	0	0		1.00
	TOTALS		56,932	0			
	G - PATIENT ACCOUNTS RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	275,538	0	0		1.00
	TOTALS		275,538	0			
500.00	Grand Total: Decreases		734,255	244,714			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 4/21/2017 3:37 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	195,525	0	0	0	0	1.00
2.00	Land Improvements	432,594	0	0	0	0	2.00
3.00	Buildings and Fixtures	10,424,102	324,363	0	324,363	0	3.00
4.00	Building Improvements	182,208	4,847	0	4,847	0	4.00
5.00	Fixed Equipment	5,622,718	91,951	0	91,951	0	5.00
6.00	Movable Equipment	8,584,630	1,093,474	0	1,093,474	415,760	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	25,441,777	1,514,635	0	1,514,635	415,760	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	25,441,777	1,514,635	0	1,514,635	415,760	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	195,525	0	1.00
2.00	Land Improvements	432,594	0	2.00
3.00	Buildings and Fixtures	10,748,465	0	3.00
4.00	Building Improvements	187,055	0	4.00
5.00	Fixed Equipment	5,714,669	0	5.00
6.00	Movable Equipment	9,262,344	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	26,540,652	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	26,540,652	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 4/21/2017 3:37 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,123,514	0	178,393	0	0	1.00
3.00	Total (sum of lines 1-2)	1,123,514	0	178,393	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,301,907		1.00
3.00	Total (sum of lines 1-2)	0	1,301,907		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 4/21/2017 3:37 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	26,540,652	0	26,540,652	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	26,540,652	0	26,540,652	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,112,927	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,112,927	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	177,268	24,844	0	0	1,315,039	1.00
3.00	Total (sum of lines 1-2)	177,268	24,844	0	0	1,315,039	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 4/21/2017 3:37 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-664,947			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-10,587	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	CAFETERIA VENDING - OTHER REV	B	-66,114	DIETARY	10.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 4/21/2017 3:37 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.00	EMPLOYEE RX PROGRAM -OTHER REV	B	-108,550	DRUGS CHARGED TO PATIENTS	73.00	0	34.00
35.00	MEDICAL RECORDS FEES -OTHER REV	B	-6,667	MEDICAL RECORDS & LIBRARY	16.00	0	35.00
36.00	SALE OF SCRAP -OTHER REV	B	-1,333	CENTRAL SERVICES & SUPPLY	14.00	0	36.00
37.00	REBATES & REFUNDS - OTHER REV	B	-28,199	CENTRAL SERVICES & SUPPLY	14.00	0	37.00
38.00	BABY PHOTO - OTHER REV	B	-23	ADMINISTRATIVE & GENERAL	5.00	0	38.00
40.00	MED SUPPLY SALES -OTHER REV	B	-28	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	40.00
41.00	NUCLEAR MED- OTHER REV	B	-523	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	41.00
43.00	OTHER SERVICES -OTHER REV	B	-18,728	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	ICG - OTHER REV	B	-2,059	ADULTS & PEDIATRICS	30.00	0	44.00
45.00	INVEST INC/UNRESTRIC- INT EXP	B	-1,125	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	45.00
45.02	TELEVISION	A	-278	OPERATION OF PLANT	7.00	0	45.02
45.03	PHYSICIAN RECRUITMENT- ADMIN	A	-16,644	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	LOBBYING EXPENSE	A	-2,941	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	CRNA	A	-589,327	ANESTHESIOLOGY	53.00	0	45.05
45.06	HOSPITAL ASSESSMENT FEE EXPENSE	A	-301,084	ADMINISTRATIVE & GENERAL	5.00	0	45.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,819,157				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 4/21/2017 3:37 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	876,652	0	876,652	0	0	1.00
2.00	60.00	LABORATORY	24,000	0	24,000	0	0	2.00
3.00	90.00	CLINIC	36,000	0	36,000	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	1,000	1,000	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	307,980	307,980	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	4,225	4,225	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	75,873	75,873	0	0	0	7.00
8.00	50.00	OPERATING ROOM	275,869	275,869	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,601,599	664,947	936,652		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	7.00
8.00	50.00	OPERATING ROOM	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	0		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	90.00	CLINIC	0	0	0	0		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	1,000		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	307,980		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	4,225		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	75,873		7.00
8.00	50.00	OPERATING ROOM	0	0	0	275,869		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	664,947		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 4/21/2017 3:37 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,315,039	1,315,039				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,088,922	17,740	5,106,662			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,896,763	275,252	808,524	4,980,539	4,980,539	5.00
7.00	00700	OPERATION OF PLANT	784,457	115,326	87,755	987,538	198,953	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	71,215	10,075	5,522	86,812	17,489	8.00
9.00	00900	HOUSEKEEPING	229,826	6,175	52,105	288,106	58,043	9.00
10.00	01000	DIETARY	285,321	49,956	60,641	395,918	79,763	10.00
13.00	01300	NURSING ADMINISTRATION	428,331	11,815	144,600	584,746	117,805	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	56,537	16,267	14,292	87,096	17,547	14.00
15.00	01500	PHARMACY	0	12,970	0	12,970	2,613	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	323,578	24,534	98,896	447,008	90,056	16.00
17.00	01700	SOCIAL SERVICE	50,933	0	17,657	68,590	13,818	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,665,289	146,086	664,656	2,476,031	498,831	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	70,931	2,694	22,759	96,384	19,418	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	651,073	88,766	284,074	1,023,913	206,282	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	94,278	7,899	30,557	132,734	26,741	52.00
53.00	05300	ANESTHESIOLOGY	16,879	519	0	17,398	3,505	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,598,792	60,098	256,119	1,915,009	385,805	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,275,262	23,263	196,114	1,494,639	301,116	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	66,508	703	0	67,211	13,541	63.00
65.00	06500	RESPIRATORY THERAPY	283,319	13,104	90,601	387,024	77,971	65.00
66.00	06600	PHYSICAL THERAPY	702,968	39,563	239,497	982,028	197,843	66.00
67.00	06700	OCCUPATIONAL THERAPY	95,377	0	32,814	128,191	25,826	67.00
68.00	06800	SPEECH PATHOLOGY	103,906	0	33,765	137,671	27,736	68.00
69.00	06900	ELECTROCARDIOLOGY	17,808	0	4,391	22,199	4,472	69.00
69.01	06901	CARDIAC REHABILITATION	63,682	7,498	21,454	92,634	18,662	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	428,863	0	0	428,863	86,400	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	182,423	0	0	182,423	36,752	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,864,886	0	0	1,864,886	375,707	73.00
76.00	03020	ONCOLOGY	140,999	9,439	36,281	186,719	37,617	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,021,810	137,199	957,696	4,116,705	829,363	88.00
90.00	09000	CLINIC	302,851	30,375	29,618	362,844	73,100	90.00
91.00	09100	EMERGENCY	1,815,802	88,716	310,271	2,214,789	446,200	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	609,031	8,769	177,506	795,306	160,226	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	27,467	3,197	9,069	39,733	8,005	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,631,126	1,207,998	4,687,234	27,104,657	4,457,206	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,548	0	7,548	1,521	190.00
190.01	19001	HOMECARE	0	2,008	0	2,008	405	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,871,290	97,485	393,078	2,361,853	475,828	192.00
194.00	07950	MARKETING	199,888	0	26,350	226,238	45,579	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	29,702,304	1,315,039	5,106,662	29,702,304	4,980,539	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 4/21/2017 3:37 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,186,491					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,796	117,097				8.00
9.00	00900	HOUSEKEEPING	7,843	0	353,992			9.00
10.00	01000	DIETARY	63,447	0	19,265	558,393		10.00
13.00	01300	NURSING ADMINISTRATION	15,006	0	4,556	0	722,113	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,660	0	6,273	0	0	14.00
15.00	01500	PHARMACY	16,473	0	5,002	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,160	0	9,461	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	185,538	37,075	56,335	558,393	381,303	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	3,422	2,235	1,039	0	14,456	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	111,208	25,055	33,766	0	88,889	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,032	0	3,046	0	28,679	52.00
53.00	05300	ANESTHESIOLOGY	2,189	0	665	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	76,328	14,861	23,176	0	17,966	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	29,545	279	8,971	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	893	0	271	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	16,643	0	5,053	0	17,600	65.00
66.00	06600	PHYSICAL THERAPY	50,247	12,973	15,257	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	9,522	0	2,891	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	11,988	138	3,640	0	30,217	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	174,251	1,242	52,908	0	0	88.00
90.00	09000	CLINIC	38,578	0	11,714	0	16,419	90.00
91.00	09100	EMERGENCY	112,674	22,539	34,212	0	110,398	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	11,138	0	3,382	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	4,060	0	1,233	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,015,641	116,397	302,116	558,393	705,927	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,586	0	2,911	0	0	190.00
190.01	19001	HOMECARE	2,551	0	774	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	158,713	700	48,191	0	16,186	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
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)	1,186,491	117,097	353,992	558,393	722,113	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 4/21/2017 3:37 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	131,576					14.00
15.00	01500	PHARMACY	0	37,058				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	577,685			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	82,408		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	21,224	76,907	4,291,637	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	1,109	0	138,063	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	56,598	5,501	1,551,212	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	2,970	0	204,202	52.00
53.00	05300	ANESTHESIOLOGY	0	0	9,654	0	33,411	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	124,901	0	2,558,046	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	107,664	0	1,942,214	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	2,277	0	84,193	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	11,811	0	516,102	65.00
66.00	06600	PHYSICAL THERAPY	0	0	25,409	0	1,283,757	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	3,674	0	157,691	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,834	0	167,241	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	4,303	0	30,974	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	1,329	0	125,038	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	113,783	0	23,893	0	652,939	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,793	0	3,736	0	240,704	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	37,058	88,111	0	2,365,762	73.00
76.00	03020	ONCOLOGY	0	0	2,578	0	272,897	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	32,434	0	5,206,903	88.00
90.00	09000	CLINIC	0	0	5,031	0	507,686	90.00
91.00	09100	EMERGENCY	0	0	39,573	0	2,980,385	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	7,529	0	977,581	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	43	0	53,074	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	131,576	37,058	577,685	82,408	26,341,712	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	21,566	190.00
190.01	19001	HOMECARE	0	0	0	0	5,738	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	3,061,471	192.00
194.00	07950	MARKETING	0	0	0	0	271,817	194.00
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)	131,576	37,058	577,685	82,408	29,702,304	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 4/21/2017 3:37 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	4,291,637		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	138,063		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,551,212		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	204,202		52.00
53.00	05300	ANESTHESIOLOGY	0	33,411		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,558,046		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	1,942,214		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	84,193		63.00
65.00	06500	RESPIRATORY THERAPY	0	516,102		65.00
66.00	06600	PHYSICAL THERAPY	0	1,283,757		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	157,691		67.00
68.00	06800	SPEECH PATHOLOGY	0	167,241		68.00
69.00	06900	ELECTROCARDIOLOGY	0	30,974		69.00
69.01	06901	CARDIAC REHABILITATION	0	125,038		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	652,939		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	240,704		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,365,762		73.00
76.00	03020	ONCOLOGY	0	272,897		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	5,206,903		88.00
90.00	09000	CLINIC	0	507,686		90.00
91.00	09100	EMERGENCY	0	2,980,385		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	977,581		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	53,074		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	26,341,712		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,566		190.00
190.01	19001	HOMECARE	0	5,738		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,061,471		192.00
194.00	07950	MARKETING	0	271,817		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	29,702,304		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 4/21/2017 3:37 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	17,740	17,740	17,740		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	275,252	275,252	2,808	278,060	5.00
7.00	00700	OPERATION OF PLANT	0	115,326	115,326	305	11,108	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,075	10,075	19	976	8.00
9.00	00900	HOUSEKEEPING	0	6,175	6,175	181	3,241	9.00
10.00	01000	DIETARY	0	49,956	49,956	211	4,453	10.00
13.00	01300	NURSING ADMINISTRATION	0	11,815	11,815	502	6,577	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,267	16,267	50	980	14.00
15.00	01500	PHARMACY	0	12,970	12,970	0	146	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,534	24,534	343	5,028	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	61	772	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	146,086	146,086	2,308	27,850	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	2,694	2,694	79	1,084	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	88,766	88,766	987	11,517	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,899	7,899	106	1,493	52.00
53.00	05300	ANESTHESIOLOGY	0	519	519	0	196	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	60,098	60,098	890	21,540	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	23,263	23,263	681	16,812	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	703	703	0	756	63.00
65.00	06500	RESPIRATORY THERAPY	0	13,104	13,104	315	4,353	65.00
66.00	06600	PHYSICAL THERAPY	0	39,563	39,563	832	11,046	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	114	1,442	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	117	1,549	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15	250	69.00
69.01	06901	CARDIAC REHABILITATION	0	7,498	7,498	75	1,042	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,824	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,052	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	20,976	73.00
76.00	03020	ONCOLOGY	0	9,439	9,439	126	2,100	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	137,199	137,199	3,330	46,292	88.00
90.00	09000	CLINIC	0	30,375	30,375	103	4,081	90.00
91.00	09100	EMERGENCY	0	88,716	88,716	1,078	24,912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	8,769	8,769	616	8,946	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	3,197	3,197	31	447	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,207,998	1,207,998	16,283	248,841	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,548	7,548	0	85	190.00
190.01	19001	HOMECARE	0	2,008	2,008	0	23	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	97,485	97,485	1,365	26,566	192.00
194.00	07950	MARKETING	0	0	0	92	2,545	194.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,315,039	1,315,039	17,740	278,060	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 4/21/2017 3:37 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	126,739					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,367	12,437				8.00
9.00	00900	HOUSEKEEPING	838	0	10,435			9.00
10.00	01000	DIETARY	6,777	0	568	61,965		10.00
13.00	01300	NURSING ADMINISTRATION	1,603	0	134	0	20,631	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,207	0	185	0	0	14.00
15.00	01500	PHARMACY	1,760	0	147	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,328	0	279	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,818	3,938	1,661	61,965	10,895	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	366	237	31	0	413	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,879	2,661	995	0	2,540	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,072	0	90	0	819	52.00
53.00	05300	ANESTHESIOLOGY	234	0	20	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,153	1,578	683	0	513	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,156	30	264	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	95	0	8	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,778	0	149	0	503	65.00
66.00	06600	PHYSICAL THERAPY	5,367	1,378	450	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	1,017	0	85	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	1,281	15	107	0	863	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	18,613	132	1,560	0	0	88.00
90.00	09000	CLINIC	4,121	0	345	0	469	90.00
91.00	09100	EMERGENCY	12,036	2,394	1,008	0	3,154	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,190	0	100	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	434	0	36	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	108,490	12,363	8,905	61,965	20,169	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,024	0	86	0	0	190.00
190.01	19001	HOMECARE	272	0	23	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,953	74	1,421	0	462	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
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)	126,739	12,437	10,435	61,965	20,631	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 4/21/2017 3:37 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,689					14.00
15.00	01500	PHARMACY	0	15,023				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	33,512			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	833		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,232	777	276,530	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	64	0	4,968	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	3,286	56	122,687	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	172	0	11,651	52.00
53.00	05300	ANESTHESIOLOGY	0	0	560	0	1,529	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	7,228	0	100,683	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	6,251	0	50,457	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	132	0	1,694	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	686	0	20,888	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,475	0	60,111	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	213	0	1,769	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	106	0	1,772	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	250	0	515	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	77	0	9,794	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,026	0	1,387	0	23,237	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,663	0	217	0	4,932	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,023	5,115	0	41,114	73.00
76.00	03020	ONCOLOGY	0	0	150	0	14,081	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,883	0	209,009	88.00
90.00	09000	CLINIC	0	0	292	0	39,786	90.00
91.00	09100	EMERGENCY	0	0	2,297	0	135,595	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	437	0	20,058	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	2	0	4,147	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,689	15,023	33,512	833	1,157,007	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	8,743	190.00
190.01	19001	HOMECARE	0	0	0	0	2,326	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	144,326	192.00
194.00	07950	MARKETING	0	0	0	0	2,637	194.00
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)	19,689	15,023	33,512	833	1,315,039	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 4/21/2017 3:37 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	276,530		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	4,968		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	122,687		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,651		52.00
53.00	05300	ANESTHESIOLOGY	0	1,529		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	100,683		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	50,457		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,694		63.00
65.00	06500	RESPIRATORY THERAPY	0	20,888		65.00
66.00	06600	PHYSICAL THERAPY	0	60,111		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,769		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,772		68.00
69.00	06900	ELECTROCARDIOLOGY	0	515		69.00
69.01	06901	CARDIAC REHABILITATION	0	9,794		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23,237		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,932		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	41,114		73.00
76.00	03020	ONCOLOGY	0	14,081		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	209,009		88.00
90.00	09000	CLINIC	0	39,786		90.00
91.00	09100	EMERGENCY	0	135,595		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	20,058		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	4,147		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,157,007		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,743		190.00
190.01	19001	HOMECARE	0	2,326		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	144,326		192.00
194.00	07950	MARKETING	0	2,637		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	1,315,039		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 4/21/2017 3:37 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	78,577					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,060	14,694,144				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,447	2,326,486	-4,980,539	24,721,765		5.00
7.00	00700	OPERATION OF PLANT	6,891	252,510	0	987,538	55,821	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	602	15,889	0	86,812	602	8.00
9.00	00900	HOUSEKEEPING	369	149,929	0	288,106	369	9.00
10.00	01000	DIETARY	2,985	174,492	0	395,918	2,985	10.00
13.00	01300	NURSING ADMINISTRATION	706	416,080	0	584,746	706	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	972	41,124	0	87,096	972	14.00
15.00	01500	PHARMACY	775	0	0	12,970	775	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,466	284,569	0	447,008	1,466	16.00
17.00	01700	SOCIAL SERVICE	0	50,806	0	68,590	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,729	1,912,513	0	2,476,031	8,729	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	161	65,488	0	96,384	161	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,304	817,409	0	1,023,913	5,232	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	472	87,925	0	132,734	472	52.00
53.00	05300	ANESTHESIOLOGY	31	0	0	17,398	103	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,591	736,970	0	1,915,009	3,591	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,390	564,308	0	1,494,639	1,390	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	42	0	0	67,211	42	63.00
65.00	06500	RESPIRATORY THERAPY	783	260,700	0	387,024	783	65.00
66.00	06600	PHYSICAL THERAPY	2,364	689,140	0	982,028	2,364	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	94,420	0	128,191	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	97,157	0	137,671	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	12,634	0	22,199	0	69.00
69.01	06901	CARDIAC REHABILITATION	448	61,732	0	92,634	448	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	428,863	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	182,423	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,864,886	0	73.00
76.00	03020	ONCOLOGY	564	104,396	0	186,719	564	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,198	2,755,711	0	4,116,705	8,198	88.00
90.00	09000	CLINIC	1,815	85,223	0	362,844	1,815	90.00
91.00	09100	EMERGENCY	5,301	892,790	0	2,214,789	5,301	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	524	510,764	0	795,306	524	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	191	26,096	0	39,733	191	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	72,181	13,487,261	-4,980,539	22,124,118	47,783	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	451	0	0	7,548	451	190.00
190.01	19001	HOMECARE	120	0	0	2,008	120	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,825	1,131,062	0	2,361,853	7,467	192.00
194.00	07950	MARKETING	0	75,821	0	226,238	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,315,039	5,106,662		4,980,539	1,186,491	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.735673	0.347530		0.201464	21.255280	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		17,740		278,060	126,739	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001207		0.011248	2.270454	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 4/21/2017 3:37 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	
			8.00	9.00	10.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	133,456					8.00
9.00	00900	HOUSEKEEPING	0	54,850				9.00
10.00	01000	DIETARY	0	2,985	100			10.00
13.00	01300	NURSING ADMINISTRATION	0	706	0	86,819		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	972	0	0	2,885,032	14.00
15.00	01500	PHARMACY	0	775	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,466	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,255	8,729	100	45,844	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	2,547	161	0	1,738	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,555	5,232	0	10,687	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	472	0	3,448	0	52.00
53.00	05300	ANESTHESIOLOGY	0	103	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,937	3,591	0	2,160	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	318	1,390	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	42	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	783	0	2,116	0	65.00
66.00	06600	PHYSICAL THERAPY	14,785	2,364	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	448	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,494,880	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	390,152	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	157	564	0	3,633	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,416	8,198	0	0	0	88.00
90.00	09000	CLINIC	0	1,815	0	1,974	0	90.00
91.00	09100	EMERGENCY	25,688	5,301	0	13,273	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	524	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	191	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	132,658	46,812	100	84,873	2,885,032	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	451	0	0	0	190.00
190.01	19001	HOMECARE	0	120	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	798	7,467	0	1,946	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	117,097	353,992	558,393	722,113	131,576	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.877420	6.453820	5,583.930000	8.317454	0.045606	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,437	10,435	61,965	20,631	19,689	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.093192	0.190246	619.650000	0.237632	0.006825	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 4/21/2017 3:37 pm

		Cost Center Description	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (ALLOCATION OF TIME)		
			15.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	60,319,328			16.00
17.00	01700	SOCIAL SERVICE	0	0	9,888		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,216,137	9,228		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	0	115,847	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	5,909,796	660		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	310,096	0		52.00
53.00	05300	ANESTHESIOLOGY	0	1,008,058	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,041,089	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	11,241,925	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	237,783	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	1,233,272	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,653,102	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	383,583	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	191,470	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	449,269	0		69.00
69.01	06901	CARDIAC REHABILITATION	0	138,728	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,494,880	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	390,152	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	9,200,237	0		73.00
76.00	03020	ONCOLOGY	0	269,186	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	3,386,642	0		88.00
90.00	09000	CLINIC	0	525,301	0		90.00
91.00	09100	EMERGENCY	0	4,132,131	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	786,188	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	4,456	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	60,319,328	9,888		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	HOMECARE	0	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	MARKETING	0	0	0		194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	37,058	577,685	82,408		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	370.580000	0.009577	8.334142		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,023	33,512	833		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	150.230000	0.000556	0.084244		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 4/21/2017 3:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,291,637		4,291,637	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	138,063		138,063	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,551,212		1,551,212	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	204,202		204,202	0	0	52.00
53.00	05300	ANESTHESIOLOGY	33,411		33,411	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,558,046		2,558,046	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,942,214		1,942,214	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	84,193		84,193	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	516,102	0	516,102	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,283,757	0	1,283,757	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	157,691	0	157,691	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	167,241	0	167,241	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	30,974		30,974	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	125,038		125,038	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	652,939		652,939	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	240,704		240,704	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,365,762		2,365,762	0	0	73.00
76.00	03020	ONCOLOGY	272,897		272,897	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,206,903		5,206,903	0	0	88.00
90.00	09000	CLINIC	507,686		507,686	0	0	90.00
91.00	09100	EMERGENCY	2,980,385		2,980,385	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	381,208		381,208		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	977,581		977,581		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	53,074		53,074		0	116.00
200.00		Subtotal (see instructions)	26,722,920	0	26,722,920	0	0	200.00
201.00		Less Observation Beds	381,208		381,208		0	201.00
202.00		Total (see instructions)	26,341,712	0	26,341,712	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 4/21/2017 3:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,991,912		1,991,912			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	115,847		115,847			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	780,519	5,129,277	5,909,796	0.262481	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	201,405	108,691	310,096	0.658512	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	113,145	894,913	1,008,058	0.033144	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,164,875	11,876,214	13,041,089	0.196153	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,844,437	9,397,488	11,241,925	0.172765	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	121,796	115,987	237,783	0.354075	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	944,603	288,669	1,233,272	0.418482	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	458,495	2,194,607	2,653,102	0.483870	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	180,173	203,410	383,583	0.411100	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	41,858	149,612	191,470	0.873458	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	29,256	420,013	449,269	0.068943	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	138,728	138,728	0.901318	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	884,690	1,610,190	2,494,880	0.261712	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	155,882	234,270	390,152	0.616949	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,695,122	5,505,115	9,200,237	0.257141	0.000000	73.00
76.00	03020	ONCOLOGY	0	269,186	269,186	1.013786	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,386,642	3,386,642			88.00
90.00	09000	CLINIC	0	525,301	525,301	0.966467	0.000000	90.00
91.00	09100	EMERGENCY	166,845	3,965,286	4,132,131	0.721271	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	224,225	224,225	1.700114	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	786,188	786,188			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	4,456	4,456			116.00
200.00		Subtotal (see instructions)	12,890,860	47,428,468	60,319,328			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,890,860	47,428,468	60,319,328			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 4/21/2017 3:37 pm

Title XVIII | Hospital | Cost

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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 4/21/2017 3:37 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,291,637		4,291,637	0	4,291,637	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	138,063		138,063	0	138,063	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,551,212		1,551,212	0	1,551,212	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	204,202		204,202	0	204,202	52.00
53.00	05300	ANESTHESIOLOGY	33,411		33,411	0	33,411	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,558,046		2,558,046	0	2,558,046	54.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,942,214		1,942,214	0	1,942,214	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	84,193		84,193	0	84,193	63.00
65.00	06500	RESPIRATORY THERAPY	516,102	0	516,102	0	516,102	65.00
66.00	06600	PHYSICAL THERAPY	1,283,757	0	1,283,757	0	1,283,757	66.00
67.00	06700	OCCUPATIONAL THERAPY	157,691	0	157,691	0	157,691	67.00
68.00	06800	SPEECH PATHOLOGY	167,241	0	167,241	0	167,241	68.00
69.00	06900	ELECTROCARDIOLOGY	30,974		30,974	0	30,974	69.00
69.01	06901	CARDIAC REHABILITATION	125,038		125,038	0	125,038	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	652,939		652,939	0	652,939	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	240,704		240,704	0	240,704	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,365,762		2,365,762	0	2,365,762	73.00
76.00	03020	ONCOLOGY	272,897		272,897	0	272,897	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,206,903		5,206,903	0	5,206,903	88.00
90.00	09000	CLINIC	507,686		507,686	0	507,686	90.00
91.00	09100	EMERGENCY	2,980,385		2,980,385	0	2,980,385	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	381,208		381,208		381,208	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	977,581		977,581		977,581	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	53,074		53,074		53,074	116.00
200.00		Subtotal (see instructions)	26,722,920	0	26,722,920	0	26,722,920	200.00
201.00		Less Observation Beds	381,208		381,208		381,208	201.00
202.00		Total (see instructions)	26,341,712	0	26,341,712	0	26,341,712	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 4/21/2017 3:37 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,991,912		1,991,912			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	115,847		115,847			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	780,519	5,129,277	5,909,796	0.262481	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	201,405	108,691	310,096	0.658512	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	113,145	894,913	1,008,058	0.033144	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,164,875	11,876,214	13,041,089	0.196153	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,844,437	9,397,488	11,241,925	0.172765	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	121,796	115,987	237,783	0.354075	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	944,603	288,669	1,233,272	0.418482	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	458,495	2,194,607	2,653,102	0.483870	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	180,173	203,410	383,583	0.411100	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	41,858	149,612	191,470	0.873458	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	29,256	420,013	449,269	0.068943	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	138,728	138,728	0.901318	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	884,690	1,610,190	2,494,880	0.261712	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	155,882	234,270	390,152	0.616949	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,695,122	5,505,115	9,200,237	0.257141	0.000000	73.00
76.00	03020	ONCOLOGY	0	269,186	269,186	1.013786	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,386,642	3,386,642	1.537483	0.000000	88.00
90.00	09000	CLINIC	0	525,301	525,301	0.966467	0.000000	90.00
91.00	09100	EMERGENCY	166,845	3,965,286	4,132,131	0.721271	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	224,225	224,225	1.700114	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	786,188	786,188			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	4,456	4,456			116.00
200.00		Subtotal (see instructions)	12,890,860	47,428,468	60,319,328			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,890,860	47,428,468	60,319,328			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 4/21/2017 3:37 pm

Title XIX | Hospital | Cost

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 4/21/2017 3:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	122,687	5,909,796	0.020760	347,330	7,211	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,651	310,096	0.037572	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,529	1,008,058	0.001517	34,440	52	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100,683	13,041,089	0.007720	411,735	3,179	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	50,457	11,241,925	0.004488	661,697	2,970	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,694	237,783	0.007124	46,851	334	63.00
65.00	06500	RESPIRATORY THERAPY	20,888	1,233,272	0.016937	503,983	8,536	65.00
66.00	06600	PHYSICAL THERAPY	60,111	2,653,102	0.022657	77,604	1,758	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,769	383,583	0.004612	30,683	142	67.00
68.00	06800	SPEECH PATHOLOGY	1,772	191,470	0.009255	8,502	79	68.00
69.00	06900	ELECTROCARDIOLOGY	515	449,269	0.001146	21,422	25	69.00
69.01	06901	CARDIAC REHABILITATION	9,794	138,728	0.070599	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,237	2,494,880	0.009314	295,127	2,749	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,932	390,152	0.012641	88,570	1,120	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,114	9,200,237	0.004469	1,766,823	7,896	73.00
76.00	03020	ONCOLOGY	14,081	269,186	0.052310	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	209,009	3,386,642	0.061716	0	0	88.00
90.00	09000	CLINIC	39,786	525,301	0.075739	0	0	90.00
91.00	09100	EMERGENCY	135,595	4,132,131	0.032815	13,440	441	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	24,563	224,225	0.109546	0	0	92.00
200.00		Total (lines 50-199)	875,867	57,420,925		4,308,207	36,492	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 4/21/2017 3:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 4/21/2017 3:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,909,796	0.000000	0.000000	347,330	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	310,096	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,008,058	0.000000	0.000000	34,440	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,041,089	0.000000	0.000000	411,735	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	11,241,925	0.000000	0.000000	661,697	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	237,783	0.000000	0.000000	46,851	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,233,272	0.000000	0.000000	503,983	65.00
66.00	06600	PHYSICAL THERAPY	0	2,653,102	0.000000	0.000000	77,604	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	383,583	0.000000	0.000000	30,683	67.00
68.00	06800	SPEECH PATHOLOGY	0	191,470	0.000000	0.000000	8,502	68.00
69.00	06900	ELECTROCARDIOLOGY	0	449,269	0.000000	0.000000	21,422	69.00
69.01	06901	CARDIAC REHABILITATION	0	138,728	0.000000	0.000000	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,494,880	0.000000	0.000000	295,127	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	390,152	0.000000	0.000000	88,570	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,200,237	0.000000	0.000000	1,766,823	73.00
76.00	03020	ONCOLOGY	0	269,186	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,386,642	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	525,301	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	4,132,131	0.000000	0.000000	13,440	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	224,225	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	57,420,925			4,308,207	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 4/21/2017 3:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	ONCOLOGY	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 4/21/2017 3:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.262481	0	1,792,355	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.658512	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.033144	0	302,942	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.196153	0	4,027,895	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.172765	0	4,200,541	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.354075	0	48,400	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.418482	0	124,745	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.483870	0	787,849	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.411100	0	54,640	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.873458	0	6,945	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.068943	0	177,173	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.901318	0	85,407	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.261712	0	534,367	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.616949	0	121,622	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257141	0	2,227,584	0	0	73.00
76.00	03020	ONCOLOGY	1.013786	0	126,168	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.966467	0	441,098	0	0	90.00
91.00	09100	EMERGENCY	0.721271	0	1,204,055	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.700114	0	76,783	0	0	92.00
200.00		Subtotal (see instructions)		0	16,340,569	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	16,340,569	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 4/21/2017 3:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	470,459	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	10,041	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	790,084	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	725,706	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	17,137	0		63.00
65.00	06500	RESPIRATORY THERAPY	52,204	0		65.00
66.00	06600	PHYSICAL THERAPY	381,216	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	22,463	0		67.00
68.00	06800	SPEECH PATHOLOGY	6,066	0		68.00
69.00	06900	ELECTROCARDIOLOGY	12,215	0		69.00
69.01	06901	CARDIAC REHABILITATION	76,979	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	139,850	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	75,035	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	572,803	0		73.00
76.00	03020	ONCOLOGY	127,907	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	426,307	0		90.00
91.00	09100	EMERGENCY	868,450	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	130,540	0		92.00
200.00		Subtotal (see instructions)	4,905,462	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,905,462	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 4/21/2017 3:37 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.262481	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.658512	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.033144	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.196153	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.172765	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.354075	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.418482	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.483870	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.411100	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.873458	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.068943	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.901318	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.261712	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.616949	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257141	0	0	0	0	73.00
76.00	03020	ONCOLOGY	1.013786	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.966467	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.721271	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.700114	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V | Date/Time Prepared: 4/21/2017 3:37 pm

Title XVIII | Swing Beds - SNF | Cost

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/21/2017 3:37 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,410	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,278	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,988	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	200	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)	770	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	39	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)	123	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,100	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)	957	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	134.09	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	137.30	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,291,637	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	5,230	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)	16,888	25.00
26.00	Total swing-bed cost (see instructions)	1,297,193	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,994,444	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,994,444	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,314.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,445,961	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)	1,445,961	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/21/2017 3:37 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,169,852	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,615,813	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)	1,257,986	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,257,986	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)	290	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,314.51	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	381,208	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/21/2017 3:37 pm

Title XVIII | Hospital | Cost

	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	276,530	4,291,637	0.064435	381,208	24,563	90.00
91.00	Nursing School cost	0	4,291,637	0.000000	381,208	0	91.00
92.00	Allied health cost	0	4,291,637	0.000000	381,208	0	92.00
93.00	All other Medical Education	0	4,291,637	0.000000	381,208	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/21/2017 3:37 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,410	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,278	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,988	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)	970	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	162	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)	44	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)	188	15.00
16.00	Nursery days (title V or XIX only)	12	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,291,637	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)	1,281,680	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,009,957	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,009,957	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,321.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	58,138	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)	58,138	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/21/2017 3:37 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	138,063	188	734.38	12	8,813	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	63,124	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	130,075	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)	290	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,321.32	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	383,183	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/21/2017 3:37 pm

Title XIX | Hospital | Cost

	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	276,530	4,291,637	0.064435	383,183	24,690	90.00
91.00	Nursing School cost	0	4,291,637	0.000000	383,183	0	91.00
92.00	Allied health cost	0	4,291,637	0.000000	383,183	0	92.00
93.00	All other Medical Education	0	4,291,637	0.000000	383,183	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 4/21/2017 3:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		921,846		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.262481	347,330	91,168	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.658512	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.033144	34,440	1,141	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.196153	411,735	80,763	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.172765	661,697	114,318	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.354075	46,851	16,589	63.00
65.00	06500	RESPIRATORY THERAPY	0.418482	503,983	210,908	65.00
66.00	06600	PHYSICAL THERAPY	0.483870	77,604	37,550	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.411100	30,683	12,614	67.00
68.00	06800	SPEECH PATHOLOGY	0.873458	8,502	7,426	68.00
69.00	06900	ELECTROCARDIOLOGY	0.068943	21,422	1,477	69.00
69.01	06901	CARDIAC REHABILITATION	0.901318	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.261712	295,127	77,238	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.616949	88,570	54,643	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257141	1,766,823	454,323	73.00
76.00	03020	ONCOLOGY	1.013786	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.966467	0	0	90.00
91.00	09100	EMERGENCY	0.721271	13,440	9,694	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.700114	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		4,308,207	1,169,852	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)		4,308,207		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3

Component CCN: 15-Z305 | Date/Time Prepared: 4/21/2017 3:37 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.262481	17,746	4,658	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.658512	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.033144	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.196153	52,922	10,381	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.172765	175,067	30,245	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.354075	25,521	9,036	63.00
65.00	06500	RESPIRATORY THERAPY	0.418482	216,073	90,423	65.00
66.00	06600	PHYSICAL THERAPY	0.483870	283,634	137,242	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.411100	108,643	44,663	67.00
68.00	06800	SPEECH PATHOLOGY	0.873458	12,550	10,962	68.00
69.00	06900	ELECTROCARDIOLOGY	0.068943	2,132	147	69.00
69.01	06901	CARDIAC REHABILITATION	0.901318	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.261712	87,372	22,866	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.616949	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257141	153,625	39,503	73.00
76.00	03020	ONCOLOGY	1.013786	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.966467	0	0	90.00
91.00	09100	EMERGENCY	0.721271	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.700114	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,135,285	400,126	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,135,285		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 4/21/2017 3:37 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		28,612		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		12,909		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.262481	25,386	6,663	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.658512	18,806	12,384	52.00
53.00	05300	ANESTHESIOLOGY	0.033144	4,670	155	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.196153	18,478	3,625	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.172765	27,934	4,826	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.354075	1,941	687	63.00
65.00	06500	RESPIRATORY THERAPY	0.418482	10,372	4,340	65.00
66.00	06600	PHYSICAL THERAPY	0.483870	844	408	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.411100	378	155	67.00
68.00	06800	SPEECH PATHOLOGY	0.873458	1,784	1,558	68.00
69.00	06900	ELECTROCARDIOLOGY	0.068943	360	25	69.00
69.01	06901	CARDIAC REHABILITATION	0.901318	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.261712	25,508	6,676	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.616949	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257141	66,229	17,030	73.00
76.00	03020	ONCOLOGY	1.013786	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.537483	0	0	88.00
90.00	09000	CLINIC	0.966467	0	0	90.00
91.00	09100	EMERGENCY	0.721271	6,366	4,592	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.700114	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		209,056	63,124	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)		209,056		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3

Component CCN: 15-Z305 | Date/Time Prepared: 4/21/2017 3:37 pm

Title XIX | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.262481	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.658512	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.033144	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.196153	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.172765	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.354075	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.418482	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.483870	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.411100	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.873458	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.068943	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.901318	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.261712	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.616949	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257141	0	0	73.00
76.00	03020	ONCOLOGY	1.013786	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.537483	0	0	88.00
90.00	09000	CLINIC	0.966467	0	0	90.00
91.00	09100	EMERGENCY	0.721271	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.700114	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1305	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 4/21/2017 3:37 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,905,462	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,905,462	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,954,517	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	37,748	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,441,468	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,475,301	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,475,301	30.00
31.00	Primary payer payments	1,745	31.00
32.00	Subtotal (line 30 minus line 31)	2,473,556	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)	423,512	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	275,283	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	402,827	36.00
37.00	Subtotal (see instructions)	2,748,839	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,748,839	40.00
40.01	Sequestration adjustment (see instructions)	54,977	40.01
41.00	Interim payments	2,524,040	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	169,822	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I Date/Time Prepared: 4/21/2017 3:37 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,183,571		2,524,040	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	03/22/2016	102,000		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)		102,000		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,285,571		2,524,040	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		58,863		169,822	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,344,434		2,693,862	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 4/21/2017 3:37 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,532,014		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	03/22/2016	68,400		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)		68,400		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,600,414		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		25,579		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,625,993		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1305	Period: From 10/01/2015 To 09/30/2016	Worksheet E-1 Part II Date/Time Prepared: 4/21/2017 3:37 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	583	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,100	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	76	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,988	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	60,319,328	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	396,501	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1305 Component CCN: 15-Z305	Period: From 10/01/2015 To 09/30/2016	Worksheet E-2 Date/Time Prepared: 4/21/2017 3:37 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,270,566	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	404,127	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	957	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,674,693	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,674,693	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,674,693	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	15,516	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,659,177	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,659,177	0	19.00
19.01	Sequestration adjustment (see instructions)	33,184	0	19.01
20.00	Interim payments	1,600,414	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	25,579	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1305 Component CCN: 15-Z305	Period: From 10/01/2015 To 09/30/2016	Worksheet E-2 Date/Time Prepared: 4/21/2017 3:37 pm
	Title XIX	Swing Beds - SNF	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1305	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part V Date/Time Prepared: 4/21/2017 3:37 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,615,813	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,615,813	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,641,971	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,641,971	19.00
20.00	Deductibles (exclude professional component)	281,510	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,360,461	22.00
23.00	Coinsurance	644	23.00
24.00	Subtotal (line 22 minus line 23)	2,359,817	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	49,943	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	32,463	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	39,172	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,392,280	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	2,392,280	30.00
30.01	Sequestration adjustment (see instructions)	47,846	30.01
31.00	Interim payments	2,285,571	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	58,863	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1305	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part VII Date/Time Prepared: 4/21/2017 3:37 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	130,075		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	130,075	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	130,075	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	41,521		8.00
9.00	Ancillary service charges	209,056	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	250,577	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	250,577	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	120,502	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	130,075	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	130,075	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	130,075	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	130,075	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	130,075	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	130,075	0	40.00
41.00	Interim payments	89,145	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	40,930	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G | Date/Time Prepared: 4/21/2017 3:37 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,889,797	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,759,938	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,372,635	0	0	0	6.00
7.00	Inventory	371,731	0	0	0	7.00
8.00	Prepaid expenses	65,511	0	0	0	8.00
9.00	Other current assets	3,092,256	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)	10,806,598	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	195,525	0	0	0	12.00
13.00	Land improvements	432,594	0	0	0	13.00
14.00	Accumulated depreciation	-330,024	0	0	0	14.00
15.00	Buildings	10,748,465	0	0	0	15.00
16.00	Accumulated depreciation	-6,532,227	0	0	0	16.00
17.00	Leasehold improvements	187,056	0	0	0	17.00
18.00	Accumulated depreciation	-163,953	0	0	0	18.00
19.00	Fixed equipment	5,714,668	0	0	0	19.00
20.00	Accumulated depreciation	-3,887,105	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	9,262,345	0	0	0	23.00
24.00	Accumulated depreciation	-6,902,895	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	8,724,449	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	2,637,586	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,637,586	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	22,168,633	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,586,171	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,669,185	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	681,281	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	111,071	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,047,708	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	5,399,191	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	818,734	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6,217,925	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,265,633	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	11,903,000				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)	11,903,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	22,168,633	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-1 | Date/Time Prepared: 4/21/2017 3:37 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		9,579,423		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,323,577				2.00
3.00	Total (sum of line 1 and line 2)		11,903,000		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)		11,903,000		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)		11,903,000		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 4/21/2017 3:37 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,107,759		2,107,759	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,107,759		2,107,759	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,107,759		2,107,759	17.00
18.00	Ancillary services	10,616,256	38,536,370	49,152,626	18.00
19.00	Outpatient services	166,845	8,101,454	8,268,299	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		786,188	786,188	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	4,456	4,456	26.00
27.00	HCC SERVICES	0	0	0	27.00
27.01	PHSYCISIAN SERVICES	369	2,147,145	2,147,514	27.01
27.02	PRO FEES	304,305	455	304,760	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	13,195,534	49,576,068	62,771,602	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,521,461		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)		31,521,461		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-3 | Date/Time Prepared: 4/21/2017 3:37 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	62,771,602	1.00
2.00	Less contractual allowances and discounts on patients' accounts	30,066,786	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,704,816	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,521,461	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,183,355	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	984,171	24.00
24.01	NON OP	156,051	24.01
25.00	Total other income (sum of lines 6-24)	1,140,222	25.00
26.00	Total (line 5 plus line 25)	2,323,577	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,323,577	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1305 HHA CCN: 15-7078 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H | Date/Time Prepared: 4/21/2017 3:37 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	98,372	0	72,360	0	25,906	196,638	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	273,417	0	0	0	0	273,417	6.00
7.00	Physical Therapy	55,438	0	0	0	0	55,438	7.00
8.00	Occupational Therapy	12,877	0	0	0	0	12,877	8.00
9.00	Speech Pathology	4,683	0	0	0	0	4,683	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	122,910	0	0	0	0	122,910	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	567,697	0	72,360	0	25,906	665,963	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	-56,932	139,706	0	139,706			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	273,417	0	273,417			6.00
7.00	Physical Therapy	0	55,438	0	55,438			7.00
8.00	Occupational Therapy	0	12,877	0	12,877			8.00
9.00	Speech Pathology	0	4,683	0	4,683			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	122,910	0	122,910			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-56,932	609,031	0	609,031			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-1305 HHA CCN: 15-7078 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-1 Part I Date/Time Prepared: 4/21/2017 3:37 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	139,706	0	0	0	0	139,706	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	273,417	0	0	0	0	273,417	6.00
7.00	Physical Therapy	55,438	0	0	0	0	55,438	7.00
8.00	Occupational Therapy	12,877	0	0	0	0	12,877	8.00
9.00	Speech Pathology	4,683	0	0	0	0	4,683	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	122,910	0	0	0	0	122,910	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	609,031	0	0	0	0	609,031	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	139,706			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	81,390	354,807		6.00
7.00	Physical Therapy	16,502	71,940		7.00
8.00	Occupational Therapy	3,833	16,710		8.00
9.00	Speech Pathology	1,394	6,077		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Home Health Aide	36,587	159,497		11.00
12.00	Supplies (see instructions)	0	0		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		609,031		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-1 Part II | Date/Time Prepared: 4/21/2017 3:37 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-139,706	469,325	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	273,417	6.00
7.00	Physical Therapy	0	0	0	0	0	55,438	7.00
8.00	Occupational Therapy	0	0	0	0	0	12,877	8.00
9.00	Speech Pathology	0	0	0	0	0	4,683	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	122,910	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-139,706	469,325	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		139,706	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.297674	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-2 Part I | Date/Time Prepared: 4/21/2017 3:37 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		0	1.00	4.00	4A	5.00	7.00	
1.00	Administrative and General	0	8,769	177,506	186,275	37,528	11,138	1.00
2.00	Skilled Nursing Care	354,807	0	0	354,807	71,482	0	2.00
3.00	Physical Therapy	71,940	0	0	71,940	14,493	0	3.00
4.00	Occupational Therapy	16,710	0	0	16,710	3,366	0	4.00
5.00	Speech Pathology	6,077	0	0	6,077	1,224	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	159,497	0	0	159,497	32,133	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)	609,031	8,769	177,506	795,306	160,226	11,138	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		8.00	9.00	10.00	13.00	14.00	15.00	
1.00	Administrative and General	0	3,382	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)	0	3,382	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

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

Period: From 10/01/2015 To 09/30/2016

Worksheet H-2 Part I Date/Time Prepared: 4/21/2017 3:37 pm

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	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		16.00	17.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	7,529	0	245,852	0	245,852		1.00
2.00	Skilled Nursing Care	0	0	426,289	0	426,289	143,229	2.00
3.00	Physical Therapy	0	0	86,433	0	86,433	29,040	3.00
4.00	Occupational Therapy	0	0	20,076	0	20,076	6,745	4.00
5.00	Speech Pathology	0	0	7,301	0	7,301	2,453	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	191,630	0	191,630	64,385	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)	7,529	0	977,581	0	977,581	245,852	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.						0.335988	21.00

	Cost Center Description	Total HHA Costs	
		28.00	
1.00	Administrative and General		1.00
2.00	Skilled Nursing Care	569,518	2.00
3.00	Physical Therapy	115,473	3.00
4.00	Occupational Therapy	26,821	4.00
5.00	Speech Pathology	9,754	5.00
6.00	Medical Social Services	0	6.00
7.00	Home Health Aide	256,015	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
19.50	Telemedicine	0	19.50
20.00	Total (sum of lines 1-19) (2)	977,581	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

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

Period: From 10/01/2015 To 09/30/2016

Worksheet H-2 Part II Date/Time Prepared: 4/21/2017 3:37 pm

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		1.00	4.00	5A	5.00	7.00	8.00	
1.00	Administrative and General	524	510,764	0	186,275	524	0	1.00
2.00	Skilled Nursing Care	0	0	0	354,807	0	0	2.00
3.00	Physical Therapy	0	0	0	71,940	0	0	3.00
4.00	Occupational Therapy	0	0	0	16,710	0	0	4.00
5.00	Speech Pathology	0	0	0	6,077	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	159,497	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	524	510,764		795,306	524	0	20.00
21.00	Total cost to be allocated	8,769	177,506		160,226	11,138	0	21.00
22.00	Unit cost multiplier	16.734733	0.347530		0.201465	21.255725	0.000000	22.00

	Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		9.00	10.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	524	0	0	0	0	786,188	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	524	0	0	0	0	786,188	20.00
21.00	Total cost to be allocated	3,382	0	0	0	0	7,529	21.00
22.00	Unit cost multiplier	6.454198	0.000000	0.000000	0.000000	0.000000	0.009577	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

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

Period:
From 10/01/2015
To 09/30/2016

Worksheet H-2
Part II
Date/Time Prepared:
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	Cost Center Description	SOCIAL SERVICE (ALLOCATION OF TIME)		
		17.00		
1.00	Administrative and General	0		1.00
2.00	Skilled Nursing Care	0		2.00
3.00	Physical Therapy	0		3.00
4.00	Occupational Therapy	0		4.00
5.00	Speech Pathology	0		5.00
6.00	Medical Social Services	0		6.00
7.00	Home Health Aide	0		7.00
8.00	Supplies (see instructions)	0		8.00
9.00	Drugs	0		9.00
10.00	DME	0		10.00
11.00	Home Dialysis Aide Services	0		11.00
12.00	Respiratory Therapy	0		12.00
13.00	Private Duty Nursing	0		13.00
14.00	Clinic	0		14.00
15.00	Health Promotion Activities	0		15.00
16.00	Day Care Program	0		16.00
17.00	Home Delivered Meals Program	0		17.00
18.00	Homemaker Service	0		18.00
19.00	All Others (specify)	0		19.00
19.50	Telemedicine	0		19.50
20.00	Total (sum of lines 1-19)	0		20.00
21.00	Total cost to be allocated	0		21.00
22.00	Unit cost multiplier	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-3 Part I | Date/Time Prepared: 4/21/2017 3:37 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	569,518		569,518	1,256	453.44	1.00
2.00	Physical Therapy	3.00	115,473	0	115,473	663	174.17	2.00
3.00	Occupational Therapy	4.00	26,821	0	26,821	154	174.16	3.00
4.00	Speech Pathology	5.00	9,754	0	9,754	56	174.18	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	256,015		256,015	2,063	124.10	6.00
7.00	Total (sum of lines 1-6)		977,581	0	977,581	4,192		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		23844	0	5			8.00
8.01	Skilled Nursing Care		50031	0	250			8.01
8.02	Skilled Nursing Care		99915	0	946			8.02
9.00	Physical Therapy		23844	0	23			9.00
9.01	Physical Therapy		50031	0	106			9.01
9.02	Physical Therapy		99915	0	534			9.02
10.00	Occupational Therapy		23844	0	0			10.00
10.01	Occupational Therapy		50031	0	34			10.01
10.02	Occupational Therapy		99915	0	121			10.02
11.00	Speech Pathology		23844	0	0			11.00
11.01	Speech Pathology		50031	0	0			11.01
11.02	Speech Pathology		99915	0	57			11.02
12.00	Medical Social Services		23844	0	0			12.00
12.01	Medical Social Services		50031	0	0			12.01
12.02	Medical Social Services		99915	0	0			12.02
13.00	Home Health Aide		23844	0	13			13.00
13.01	Home Health Aide		50031	0	114			13.01
13.02	Home Health Aide		99915	0	677			13.02
14.00	Total (sum of lines 8-13)			0	2,880			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	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,201		0	544,581		1.00
2.00	Physical Therapy	0	663		0	115,475		2.00
3.00	Occupational Therapy	0	155		0	26,995		3.00
4.00	Speech Pathology	0	57		0	9,928		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	804		0	99,776		6.00
7.00	Total (sum of lines 1-6)	0	2,880		0	796,755		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-3 Part I | Date/Time Prepared: 4/21/2017 3:37 pm

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	544,581	1.00
2.00	Physical Therapy	115,475	2.00
3.00	Occupational Therapy	26,995	3.00
4.00	Speech Pathology	9,928	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	99,776	6.00
7.00	Total (sum of lines 1-6)	796,755	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
8.02	Skilled Nursing Care		8.02
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
9.02	Physical Therapy		9.02
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
10.02	Occupational Therapy		10.02
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
11.02	Speech Pathology		11.02
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
12.02	Medical Social Services		12.02
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
13.02	Home Health Aide		13.02
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-3 Part II | Date/Time Prepared: 4/21/2017 3:37 pm

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.483870	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.411100	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.873458	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.261712	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.257141	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-4 Part I-II | Date/Time Prepared: 4/21/2017 3:37 pm

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	390,922	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	13,404	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	10,196	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	1,136	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	1,361	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	417,019	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	417,019	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	417,019	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	417,019	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	417,019	31.00
31.01	Sequestration adjustment (see instructions)	0	8,340	31.01
32.00	Interim payments (see instructions)	0	408,679	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-5 | Date/Time Prepared: 4/21/2017 3:37 pm

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		408,679	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		408,679	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		0	6.02
7.00	Total Medicare program liability (see instructions)		0		408,679	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1305 | Hospice CCN: 15-1550 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O | Date/Time Prepared: 4/21/2017 3:37 pm

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	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	5,637	1,335	6,972	0	6,972	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	36	36	0	36	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)*						16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	8,663	0	8,663	0	8,663	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	11,706	0	11,706	0	11,706	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	90	0	90	0	90	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	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
100.00	TOTAL	26,096	1,371	27,467	0	27,467	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1305 | Hospice CCN: 15-1550 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O | Date/Time Prepared: 4/21/2017 3:37 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		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	6,972		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	36		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)*				16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				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	8,663		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	11,706		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0		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 & HOMEMAKER SERVICES**	0	90		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		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	27,467		100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 15-1305 | Hospice CCN: 15-1550 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O-2 | Date/Time Prepared: 4/21/2017 3:37 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	8,663	0	8,663	0	8,663	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	11,706	0	11,706	0	11,706	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	90	0	90	0	90	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	20,459	0	20,459	0	20,459	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	8,663		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	11,706		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		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 & HOMEMAKER SERVICES	0	90		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		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
100.00	TOTAL *	0	20,459		100.00

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

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

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

Period: From 10/01/2015 To 09/30/2016

Worksheet O-5

Date/Time Prepared: 4/21/2017 3:37 pm

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	3,197	3,197	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	9,069	9,069	3.00
4.00	ADMINISTRATIVE & GENERAL	6,972	8,005	14,977	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	4,060	4,060	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	1,233	1,233	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	43	43	11.00
12.00	STAFF TRANSPORTATION	36		36	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)				16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	20,459		20,459	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0		0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0		0	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	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	27,467	25,607	53,074	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

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

Period: From 10/01/2015 To 09/30/2016

Worksheet O-6
Part I
Date/Time Prepared: 4/21/2017 3:37 pm

Hospice I

	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 & FIXT	3,197	3,197				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	9,069	0	0	9,069		3.00
4.00	ADMINISTRATIVE & GENERAL	14,977	3,197	0	0	18,174	4.00
5.00	PLANT OPERATION & MAINTENANCE	4,060	0	0	0	4,060	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	1,233	0	0	0	1,233	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	43	0	0	0	43	11.00
12.00	STAFF TRANSPORTATION	36	0	0	0	36	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	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	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	20,459			9,069	29,528	51.00
52.00	HOSPICE INPATIENT RESPITE 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	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	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	53,074	3,197	0	9,069	53,074	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

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

Period: From 10/01/2015 To 09/30/2016

Worksheet O-6 Part I
Date/Time Prepared: 4/21/2017 3:37 pm

Hospice I

	Descriptions	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	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	18,174					4.00
5.00	PLANT OPERATION & MAINTENANCE	2,114	6,174				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	642	0		1,875		7.00
8.00	DIETARY	0	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	22	0		0		11.00
12.00	STAFF TRANSPORTATION	19	6,174		1,875		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	15,377					51.00
52.00	HOSPICE INPATIENT RESPITE 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						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	18,174	6,174	0	1,875	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

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

Period: From 10/01/2015 To 09/30/2016

Worksheet O-6 Part I
Date/Time Prepared: 4/21/2017 3:37 pm

Hospice I

	Descriptions	NURSING ADMINISTRATION	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		65			11.00
12.00	STAFF TRANSPORTATION	0			8,104		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						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	65	8,104	0	51.00
52.00	HOSPICE INPATIENT RESPITE 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	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						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	65	8,104	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

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

Period: From 10/01/2015 To 09/30/2016

Worksheet O-6 Part I
Date/Time Prepared: 4/21/2017 3:37 pm

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE (DELETED)	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	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	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				0		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		53,074	51.00
52.00	HOSPICE INPATIENT RESPITE 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	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	0	0	53,074	100.00

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

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

Period:
From 10/01/2015
To 09/30/2016

Worksheet O-6
Part II
Date/Time Prepared:
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Hospice I

	Cost Center Descriptions	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	191					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	9,069			3.00
4.00	ADMINISTRATIVE & GENERAL	191	0	0	-18,174	34,900	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	4,060	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	1,233	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	43	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	36	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	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	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			9,069	0	29,528	51.00
52.00	HOSPICE INPATIENT RESPITE 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	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		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. O-6, Part I)	3,197	0	9,069		18,174	100.00
101.00	UNIT COST MULTIPLIER	16.738220	0.000000	1.000000		0.520745	101.00

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

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

Period:
From 10/01/2015
To 09/30/2016

Worksheet O-6
Part II
Date/Time Prepared:
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Hospice I

	Cost Center Descriptions	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	6,134					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		6,134			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	6,134		6,134		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			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 RESPITE 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						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. O-6, Part I)	6,174	0	1,875	0	0	100.00
101.00	UNIT COST MULTIPLIER	1.006521	0.000000	0.305673	0.000000	0.000000	101.00

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

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

Period:
From 10/01/2015
To 09/30/2016

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Hospice I

	Cost Center Descriptions	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	7					10.00
11.00	MEDICAL RECORDS		7				11.00
12.00	STAFF TRANSPORTATION			55			12.00
13.00	VOLUNTEER SERVICE COORDINATION			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						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	7	7	55	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE 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	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						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. O-6, Part I)	0	65	8,104	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	9.285714	147.345455	0.000000	0.000000	101.00

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

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

Period:
From 10/01/2015
To 09/30/2016

Worksheet O-6
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Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (DELETED) (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		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	7				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	7	0			51.00
52.00	HOSPICE INPATIENT RESPITE 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					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. O-6, Part I)	0	0	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: 15-1305 Hospice CCN: 15-1550

Period: From 10/01/2015 To 09/30/2016

Worksheet O-7

Date/Time Prepared: 4/21/2017 3:37 pm

Hospice I

	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	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.483870	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.411100	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.873458	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.257141	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.172765	0	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.261712	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	ONCOLOGY	76.00	1.013786	0	0	0	10.00
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC 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
6.01	BLOOD LABORATORY	0	0	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	ONCOLOGY	0	0	0	0	0	10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-1305 | Hospice CCN: 15-1550 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O-8 | Date/Time Prepared: 4/21/2017 3:37 pm

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			53,074	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			7	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			7,582.00	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	7	0		9.00
10.00	Program cost (line 8 times line 9)	53,074	0		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			0	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			0	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			0.00	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	0	0		14.00
15.00	Program cost (line 13 times line 14)	0	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			0	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			0	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			0.00	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	0	0		19.00
20.00	Program cost (line 18 times line 19)	0	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			53,074	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			7	22.00
23.00	Average cost per diem (line 21 divided by line 22)			7,582.00	23.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1 | Date/Time Prepared: 4/21/2017 3:37 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	2,148,857	23,913	2,172,770	-377,948	1,794,822	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	240,058	0	240,058	-10,457	229,601	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	100,946	0	100,946	0	100,946	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	391,703	0	391,703	-275,538	116,165	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,881,564	23,913	2,905,477	-663,943	2,241,534	10.00
11.00	Physician Services Under Agreement	1,401	125	1,526	0	1,526	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	1,401	125	1,526	0	1,526	14.00
15.00	Medical Supplies	0	22,796	22,796	0	22,796	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	22,796	22,796	0	22,796	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,882,965	46,834	2,929,799	-663,943	2,265,856	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	79,524	79,524	0	79,524	29.00
30.00	Administrative Costs	536,689	124,188	660,877	15,553	676,430	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	536,689	203,712	740,401	15,553	755,954	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,419,654	250,546	3,670,200	-648,390	3,021,810	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1 | Date/Time Prepared: 4/21/2017 3:37 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,794,822		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	229,601		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	100,946		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	116,165		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,241,534		10.00
11.00	Physician Services Under Agreement	0	1,526		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	1,526		14.00
15.00	Medical Supplies	0	22,796		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	22,796		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,265,856		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	79,524		29.00
30.00	Administrative Costs	0	676,430		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	755,954		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	3,021,810		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

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

Period: From 10/01/2015 To 09/30/2016

Worksheet M-2

Date/Time Prepared: 4/21/2017 3:37 pm

RHC I

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	4.43	14,714	4,200	18,606		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.01	4,252	2,100	4,221		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.44	18,966		22,827	22,827	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	6.44	18,966			22,827	8.00
9.00	Physician Services Under Agreements		11			11	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,265,856	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,265,856	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					755,954	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,185,093	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,941,047	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,941,047	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,941,047	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					5,206,903	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2015 To 09/30/2016	Worksheet M-3 Date/Time Prepared: 4/21/2017 3:37 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			5,206,903	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			100,955	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			5,105,948	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			22,827	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			11	5.00
6.00	Total adjusted visits (line 4 plus line 5)			22,838	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			223.57	7.00
		Calculation of Limit (1)			
		Prior to January 1	On or After January 1		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	80.44	81.32		8.00
9.00	Rate for Program covered visits (see instructions)	223.57	223.57		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,986		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	891,150		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	5		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	1,118		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	1,118		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	892,268		16.00
16.01	Total program charges (see instructions)(from contractor's records)		454,853		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,845		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		13,428		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		663,392		16.04
16.05	Total program cost (see instructions)	0	676,820		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		49,600		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		79,682		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		676,820		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		41,644		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		718,464		22.00
23.00	Allowable bad debts (see instructions)		975		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		634		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		159		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		159		25.50
26.00	Net reimbursable amount (see instructions)		718,939		26.00
26.01	Sequestration adjustment (see instructions)		14,379		26.01
27.00	Interim payments		657,045		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		47,515		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2015 To 09/30/2016	Worksheet M-4 Date/Time Prepared: 4/21/2017 3:37 pm
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,241,534	2,241,534	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000780	0.002262	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,748	5,070	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	25,820	11,293	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	27,568	16,363	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,265,856	2,265,856	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,941,047	2,941,047	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.012167	0.007222	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	35,784	21,240	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	63,352	37,603	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	225	652	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	281.56	57.67	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	84	312	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	23,651	17,993	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		100,955	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		41,644	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2015 To 09/30/2016	Worksheet M-5 Date/Time Prepared: 4/21/2017 3:37 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		560,945	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		03/22/2016	96,100	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		96,100	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		657,045	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		47,515	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		704,560	7.00

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