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: 15-1327	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/26/2017 3:20 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/26/2017 Time: 3:20 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 SULLIVAN COUNTY COMMUNITY HOSPITAL (15-1327) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	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	223,844	-64,846	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	33,415	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		0		0	10.00
200.00	Total	0	257,259	-64,846	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2017 2:23 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2200 NORTH SECTION STREET	PO Box: 10			1.00
2.00	City: SULLIVAN	State: IN	Zip Code: 47882-	County: SULLIVAN	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	SULLIVAN COUNTY COMMUNITY HOSPITAL	151327	45460	1	06/01/2005	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	SULLIVAN COUNTY COMMUNITY HOSPITAL	15Z327	45460		06/01/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	SULLIVAN COUNTY HOME HEALTH	157542	45460		07/23/2002	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2016	12/31/2016	20.00
21.00	Type of Control (see instructions)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2017 2:23 pm

		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.	1		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.	1		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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2017 2:23 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

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

		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	
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2017 2:23 pm

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2017 2:23 pm

		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	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.	Y		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:	102,397	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2017 2:23 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

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

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N	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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1327	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/26/2017 2:23 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2016	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: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2017 2:23 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	03/13/2017	Y	03/13/2017	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: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2017 2:23 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				Y	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.				Y	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.				N	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.					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.	BRANDENBURG		BOB		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(317) 383-3787		BBRANDENBURG@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1327	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/26/2017 2:23 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.	PARTNER		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: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/26/2017 2:23 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	21	7,686	46,248.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,686	46,248.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,464	4,896.00	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	51,144.00	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						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: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2017 2:23 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)	1,261	70	2,096			1.00
2.00	HMO and other (see instructions)	159	118				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	361	0	361			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	105			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,622	70	2,562			7.00
8.00	INTENSIVE CARE UNIT	126	15	205			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		150	232			13.00
14.00	Total (see instructions)	1,748	235	2,999	0.00	199.65	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	3,065	32	4,218	0.00	7.02	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	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	206.67	27.00
28.00	Observation Bed Days		254	1,932			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			12			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	15			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2017 2:23 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	431	12	763	1.00
2.00	HMO and other (see instructions)			40	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	431	12	763	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						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: 15-1327 | Component CCN: 15-7542 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-4 | Date/Time Prepared: 5/26/2017 2:23 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	2,281	0	0	2,281	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	110.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		0.00	2.00	0.00	2.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			2.05	0.00	2.05	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			1.42	0.00	1.42	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.40	0.00	0.40	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.04	0.00	0.04	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			1.10	0.00	1.10	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			45460			20.00
20.01				99915			20.01
		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	998	9	17	9	1,033	21.00
22.00	Skilled Nursing Visit Charges	142,537	1,279	2,423	1,287	147,526	22.00
23.00	Physical Therapy Visits	892	21	14	14	941	23.00
24.00	Physical Therapy Visit Charges	151,613	3,570	2,353	2,380	159,916	24.00
25.00	Occupational Therapy Visits	341	13	2	3	359	25.00
26.00	Occupational Therapy Visit Charges	57,970	2,210	340	510	61,030	26.00
27.00	Speech Pathology Visits	27	3	0	0	30	27.00
28.00	Speech Pathology Visit Charges	4,455	495	0	0	4,950	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	733	16	2	13	764	31.00
32.00	Home Health Aide Visit Charges	64,504	1,408	176	1,144	67,232	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,991	62	35	39	3,127	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)	421,079	8,962	5,292	5,321	440,654	35.00
36.00	Total Number of Episodes (standard/non outlier)	147		11	2	160	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	1,103	0	21	0	1,124	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/26/2017 2:23 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)	0.328450	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,516,642	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	152,848	5.00
6.00	Medicaid charges	25,797,252	6.00
7.00	Medicaid cost (line 1 times line 6)	8,473,107	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)	4,803,617	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)	2,189,410	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	10,693,040	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	3,512,129	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)	1,322,719	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)	6,126,336	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)	438,508	6,471,259	6,909,767	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	144,028	2,125,485	2,269,513	21.00
22.00	Partial payment by patients approved for charity care	32,052	105,825	137,877	22.00
23.00	Cost of charity care (line 21 minus line 22)	111,976	2,019,660	2,131,636	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	20,398,742,307	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	694,656	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	20,398,047,651	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	6,699,738,751	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	6,701,870,387	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,707,996,723	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/26/2017 2:23 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		608,501	608,501	0	608,501	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		949,459	949,459	0	949,459	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	136,200	4,036,253	4,172,453	0	4,172,453	4.00
5.01	00550	IS/ACCOUNTING/MARKETING	574,549	753,330	1,327,879	-180,616	1,147,263	5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	725,983	340,449	1,066,432	0	1,066,432	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	156,941	1,935,342	2,092,283	0	2,092,283	5.03
7.00	00700	OPERATION OF PLANT	426,947	633,784	1,060,731	0	1,060,731	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	43,177	30,169	73,346	0	73,346	8.00
9.00	00900	HOUSEKEEPING	354,583	47,444	402,027	0	402,027	9.00
10.00	01000	DIETARY	332,194	227,453	559,647	0	559,647	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	388,641	54,225	442,866	0	442,866	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	132,554	8,208	140,762	0	140,762	14.00
15.00	01500	PHARMACY	366,386	1,010,797	1,377,183	0	1,377,183	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	358,756	32,436	391,192	0	391,192	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	584,000	584,000	0	584,000	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,587,403	73,573	1,660,976	426,667	2,087,643	30.00
31.00	03100	INTENSIVE CARE UNIT	459,724	15,702	475,426	0	475,426	31.00
43.00	04300	NURSERY	0	0	0	92,886	92,886	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	683,144	288,675	971,819	-125,585	846,234	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	497,116	34,756	531,872	-519,553	12,319	52.00
53.00	05300	ANESTHESIOLOGY	0	3,826	3,826	0	3,826	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	587,332	383,535	970,867	-3,854	967,013	54.00
54.01	05401	ULTRASOUND	0	232,600	232,600	0	232,600	54.01
56.00	05600	RADIOISOTOPE	0	102,988	102,988	0	102,988	56.00
60.00	06000	LABORATORY	620,781	832,073	1,452,854	0	1,452,854	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	44,588	44,588	0	44,588	63.00
64.00	06400	INTRAVENOUS THERAPY	0	30,733	30,733	0	30,733	64.00
65.00	06500	RESPIRATORY THERAPY	446,137	88,440	534,577	-28,432	506,145	65.00
66.00	06600	PHYSICAL THERAPY	668,892	18,686	687,578	0	687,578	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	114,703	1,291	115,994	0	115,994	67.00
68.00	06800	SPEECH PATHOLOGY	65,764	684	66,448	0	66,448	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,710	3,710	0	3,710	70.00
70.01	07001	CARDIOPULMONARY	49,224	4,893	54,117	0	54,117	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	214,376	214,376	157,871	372,247	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	147,983	147,983	0	147,983	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	JV CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	862,424	600,744	1,463,168	0	1,463,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	432,546	63,452	495,998	0	495,998	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,072,101	14,439,158	25,511,259	-180,616	25,330,643	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	168,335	168,335	17,965	186,300	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	162,651	162,651	194.02
200.00		TOTAL (SUM OF LINES 118-199)	11,072,101	14,607,493	25,679,594	0	25,679,594	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/26/2017 2:23 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	13,800	622,301		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-80,048	869,411		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,130,174	3,042,279		4.00
5.01	00550	IS/ACCOUNTING/MARKETING	-9,006	1,138,257		5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	0	1,066,432		5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	-710,206	1,382,077		5.03
7.00	00700	OPERATION OF PLANT	-13,205	1,047,526		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	73,346		8.00
9.00	00900	HOUSEKEEPING	0	402,027		9.00
10.00	01000	DIETARY	0	559,647		10.00
11.00	01100	CAFETERIA	-121,210	-121,210		11.00
13.00	01300	NURSING ADMINISTRATION	-20,352	422,514		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-2,386	138,376		14.00
15.00	01500	PHARMACY	-3,434	1,373,749		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,966	384,226		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-584,000	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,087,643		30.00
31.00	03100	INTENSIVE CARE UNIT	0	475,426		31.00
43.00	04300	NURSERY	0	92,886		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	846,234		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	12,319		52.00
53.00	05300	ANESTHESIOLOGY	0	3,826		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,400	965,613		54.00
54.01	05401	ULTRASOUND	0	232,600		54.01
56.00	05600	RADIOISOTOPE	0	102,988		56.00
60.00	06000	LABORATORY	3,133	1,455,987		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	44,588		63.00
64.00	06400	INTRAVENOUS THERAPY	0	30,733		64.00
65.00	06500	RESPIRATORY THERAPY	0	506,145		65.00
66.00	06600	PHYSICAL THERAPY	0	687,578		66.00
66.01	06601	SPORTS THERAPY	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	115,994		67.00
68.00	06800	SPEECH PATHOLOGY	0	66,448		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,710		70.00
70.01	07001	CARDIOPULMONARY	0	54,117		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,193	371,054		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	147,983		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	JV CLINIC	323,924	323,924		90.01
91.00	09100	EMERGENCY	0	1,463,168		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	495,998		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,342,723	22,987,920		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	186,300		192.00
192.01	19201	MSO CLINICS	0	0		192.01
192.03	19203	FPA	0	0		192.03
194.00	07950	MEALS ON WHEELS	0	0		194.00
194.01	07951	GUEST MEALS	0	0		194.01
194.02	07952	MARKETING	0	162,651		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-2,342,723	23,336,871		200.00

RECLASSIFICATIONS | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/26/2017 2:23 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - ADVERTISING RECLASS				
1.00	MARKETING	194.02	72,808	89,843	1.00
	0		72,808	89,843	
	B - DELIVERY ROOM RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	406,254	20,413	1.00
2.00	NURSERY	43.00	81,151	11,735	2.00
	0		487,405	32,148	
	C - OR SUPPLY COST				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	129,439	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	129,439	
	D - MOB EXPENSE RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	17,965	1.00
	0		0	17,965	
	E - OXYGEN RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	28,432	1.00
	0		0	28,432	
500.00	Grand Total: Increases		560,213	297,827	500.00

RECLASSIFICATIONS | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/26/2017 2:23 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - ADVERTISING RECLASS						
1.00	IS/ACCOUNTING/MARKETING	5.01	72,808	89,843	0		1.00
	0		72,808	89,843			
	B - DELIVERY ROOM RECLASS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	487,405	32,148	0		1.00
2.00		0.00	0	0	0		2.00
	0		487,405	32,148			
	C - OR SUPPLY COST						
1.00		0.00	0	0	0		1.00
2.00	OPERATING ROOM	50.00	0	125,585	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,854	0		3.00
	0		0	129,439			
	D - MOB EXPENSE RECLASS						
1.00	IS/ACCOUNTING/MARKETING	5.01	0	17,965	0		1.00
	0		0	17,965			
	E - OXYGEN RECLASS						
1.00	RESPIRATORY THERAPY	65.00	0	28,432	0		1.00
	0		0	28,432			
500.00	Grand Total: Decreases		560,213	297,827			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2017 2:23 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	1,042,227	0	0	0	0	1.00
2.00	Land Improvements	345,187	0	0	0	0	2.00
3.00	Buildings and Fixtures	17,909,494	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,138,047	0	0	0	33,629	5.00
6.00	Movable Equipment	14,797,430	1,855,081	0	1,855,081	52,386	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,232,385	1,855,081	0	1,855,081	86,015	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	35,232,385	1,855,081	0	1,855,081	86,015	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,042,227	0	1.00
2.00	Land Improvements	345,187	0	2.00
3.00	Buildings and Fixtures	17,909,494	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	1,104,418	0	5.00
6.00	Movable Equipment	16,600,125	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,001,451	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	37,001,451	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II Date/Time Prepared: 5/26/2017 2:23 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	564,037	30,664	13,800	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	857,337	82,039	0	10,083	0	2.00
3.00	Total (sum of lines 1-2)	1,421,374	112,703	13,800	10,083	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	608,501		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	949,459		2.00
3.00	Total (sum of lines 1-2)	0	1,557,960		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/26/2017 2:23 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	20,401,326	0	20,401,326	0.551366	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	16,600,125	0	16,600,125	0.448634	0	2.00
3.00	Total (sum of lines 1-2)	37,001,451	0	37,001,451	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	564,037	30,664	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	777,470	82,039	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,341,507	112,703	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	27,600	0	0	0	622,301	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-181	10,083	0	0	869,411	2.00
3.00	Total (sum of lines 1-2)	27,419	10,083	0	0	1,491,712	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/26/2017 2:23 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 - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	11	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)	A	-443	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	7.00
8.00	Television and radio service (chapter 21)	A	-5,520	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-584,000			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	184,331			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-121,210	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-3,434	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,966	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	107	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/26/2017 2:23 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	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-79,867	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	PHYSICIAN RECRUITMENT	A	-50,727	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.00
33.01	FLOWERS & PLANTS	A	-1,680	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.01
33.02	SALES TAX	A	-8,799	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.02
33.03	LOBBYING EXPENSES	A	-1,163	OTHER ADMINISTRATIVE AND GENERAL	5.03	9	33.03
33.04	SALES OF SUPPLIES	B	-1,193	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.04
33.05	ATM RENTAL AND COMISSION	B	-1,436	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.05
33.06	MISC INCOME	B	-1,669	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.06
33.07	EDUCATION REVENUE	B	-20,352	NURSING ADMINISTRATION	13.00	0	33.07
33.08	DOMESTIC HEALTHCARE CLAIMS	B	-1,192,927	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	MISC INCOME	B	3,133	LABORATORY	60.00	0	33.09
33.10	HOSPITAL ASSESSMENT FEE	A	-459,973	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.10
33.11	SURETY BONDS	B	-1,335	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.11
33.12	MISC INCOME	B	-1,400	RADIOLOGY-DIAGNOSTIC	54.00	0	33.12
33.13	BOND ISSUANCE COST	A	13,800	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,342,723				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2017 2:23 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	FITNESS CENTER - PROP INSURN	0	181	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	FITNESS CENTER - HR	0	4,740	2.00
3.00	5.01	IS/ACCOUNTING/MARKETING	FITNESS CENTER - FISCAL ACCT	0	9,006	3.00
4.00	5.03	OTHER ADMINISTRATIVE AND GEN	FITNESS CENTER - ADMIN	0	5,893	4.00
4.01	7.00	OPERATION OF PLANT	FITNESS CENTER - MAINT	0	7,685	4.01
4.02	14.00	CENTRAL SERVICES & SUPPLY	FITNESS CENTER - MATERIALS M	0	2,386	4.02
4.06	5.03	OTHER ADMINISTRATIVE AND GEN	MSO	0	177,195	4.06
4.07	90.01	JV CLINIC	JV PAIN MANAGEMENT CLINIC	323,924	0	4.07
4.08	4.00	EMPLOYEE BENEFITS DEPARTMENT	JV PAIN MANAGEMENT CLINIC	67,493	0	4.08
4.09	0.00			0	0	4.09
4.10	0.00			0	0	4.10
5.00	0		0	391,417	207,086	5.00

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

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

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

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

6.00	C		0.00	FITNESS CENTER	100.00	6.00
7.00	C		0.00	FITNESS CENTER	100.00	7.00
8.00	C		0.00	FITNESS CENTER	100.00	8.00
9.00	C		0.00	FITNESS CENTER	100.00	9.00
10.00	C		0.00	FITNESS CENTER	100.00	10.00
10.01	C		0.00	FITNESS CENTER	100.00	10.01
10.02	C		0.00	FITNESS CENTER	100.00	10.02
10.03	C		0.00	JV PAIN CLINIC	100.00	10.03
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2017 2:23 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-181	11		1.00
2.00	-4,740	0		2.00
3.00	-9,006	0		3.00
4.00	-5,893	0		4.00
4.01	-7,685	0		4.01
4.02	-2,386	0		4.02
4.06	-177,195	0		4.06
4.07	323,924	0		4.07
4.08	67,493	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
5.00	184,331			5.00

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

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

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

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

6.00	FITNESS CENTER		6.00
7.00	FITNESS CENTER		7.00
8.00	FITNESS CENTER		8.00
9.00	FITNESS CENTER		9.00
10.00	FITNESS CENTER		10.00
10.01	FITNESS CENTER		10.01
10.02	FITNESS CENTER		10.02
10.03	JV PAIN CLINIC		10.03
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2017 2:23 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	60.00	LABORATORY	24,000	0	24,000	0	0	1.00
2.00	19.00	NONPHYSICIAN ANESTHETISTS	584,000	584,000	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			608,000	584,000	24,000		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	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0		1.00
2.00	19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	584,000		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	584,000		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/26/2017 2:23 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	622,301	622,301				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	869,411		869,411			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,042,279	3,629	5,179	3,051,087		4.00
5.01	00550	IS/ACCOUNTING/MARKETING	1,138,257	15,923	22,727	137,201	1,314,108	5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	1,066,432	13,421	19,156	198,519	1,297,528	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	1,382,077	22,007	31,410	42,915	1,478,409	5.03
7.00	00700	OPERATION OF PLANT	1,047,526	70,749	100,980	116,748	1,336,003	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	73,346	3,689	5,265	11,807	94,107	8.00
9.00	00900	HOUSEKEEPING	402,027	8,612	12,292	96,960	519,891	9.00
10.00	01000	DIETARY	559,647	16,823	24,012	90,838	691,320	10.00
11.00	01100	CAFETERIA	-121,210	6,124	8,740	0	-106,346	11.00
13.00	01300	NURSING ADMINISTRATION	422,514	3,762	5,370	106,273	537,919	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	138,376	15,703	22,412	36,247	212,738	14.00
15.00	01500	PHARMACY	1,373,749	9,546	13,625	100,188	1,497,108	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	384,226	19,879	28,373	98,101	530,579	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,087,643	104,924	149,755	545,172	2,887,494	30.00
31.00	03100	INTENSIVE CARE UNIT	475,426	27,730	39,579	125,711	668,446	31.00
43.00	04300	NURSERY	92,886	2,221	3,170	22,191	120,468	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	846,234	89,647	127,953	186,805	1,250,639	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,319	3,115	4,446	2,655	22,535	52.00
53.00	05300	ANESTHESIOLOGY	3,826	0	0	0	3,826	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	965,613	37,716	53,832	160,605	1,217,766	54.00
54.01	05401	ULTRASOUND	232,600	2,268	3,237	0	238,105	54.01
56.00	05600	RADIOISOTOPE	102,988	2,802	3,999	0	109,789	56.00
60.00	06000	LABORATORY	1,455,987	20,212	28,849	169,752	1,674,800	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	44,588	1,267	1,809	0	47,664	63.00
64.00	06400	INTRAVENOUS THERAPY	30,733	2,248	3,209	0	36,190	64.00
65.00	06500	RESPIRATORY THERAPY	506,145	16,730	23,879	121,996	668,750	65.00
66.00	06600	PHYSICAL THERAPY	687,578	27,430	39,150	182,908	937,066	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	115,994	5,477	7,817	31,365	160,653	67.00
68.00	06800	SPEECH PATHOLOGY	66,448	1,207	1,723	17,983	87,361	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,710	1,474	2,104	0	7,288	70.00
70.01	07001	CARDIOPULMONARY	54,117	7,685	10,968	13,460	86,230	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	371,054	0	0	0	371,054	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	147,983	0	0	0	147,983	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	JV CLINIC	323,924	13,168	0	60,670	397,762	90.01
91.00	09100	EMERGENCY	1,463,168	39,717	56,688	235,829	1,795,402	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	495,998	0	0	118,279	614,277	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,987,920	616,905	861,708	3,031,178	22,954,912	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,515	5,018	0	8,533	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	186,300	0	0	0	186,300	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	162,651	1,881	2,685	19,909	187,126	194.02
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)	23,336,871	622,301	869,411	3,051,087	23,336,871	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/26/2017 2:23 pm

		Cost Center Description	IS/ACCOUNTING/ MARKETING	Subtotal	BUSINESS OFFICE & ADMITTING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
			5.01	5A.01	5.02	5A.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	IS/ACCOUNTING/MARKETING	1,314,108					5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	77,736	1,375,264	1,375,264			5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	88,573	1,566,982	101,547	1,668,529	1,668,529	5.03
7.00	00700	OPERATION OF PLANT	80,041	1,416,044	91,765	1,507,809	115,539	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,638	99,745	6,464	106,209	8,138	8.00
9.00	00900	HOUSEKEEPING	31,147	551,038	35,709	586,747	44,961	9.00
10.00	01000	DIETARY	41,418	732,738	47,484	780,222	59,786	10.00
11.00	01100	CAFETERIA	0	-106,346	0	-106,346	0	11.00
13.00	01300	NURSING ADMINISTRATION	32,227	570,146	36,948	607,094	46,520	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,745	225,483	14,612	240,095	18,398	14.00
15.00	01500	PHARMACY	89,693	1,586,801	102,831	1,689,632	129,471	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,788	562,367	36,444	598,811	45,885	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	172,997	3,060,491	198,322	3,258,813	249,713	30.00
31.00	03100	INTENSIVE CARE UNIT	40,047	708,493	45,913	754,406	57,808	31.00
43.00	04300	NURSERY	7,217	127,685	8,274	135,959	10,418	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	74,927	1,325,566	85,902	1,411,468	108,157	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,350	23,885	1,548	25,433	1,949	52.00
53.00	05300	ANESTHESIOLOGY	229	4,055	263	4,318	331	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,958	1,290,724	83,644	1,374,368	105,314	54.00
54.01	05401	ULTRASOUND	14,265	252,370	16,355	268,725	20,592	54.01
56.00	05600	RADIOISOTOPE	6,578	116,367	7,541	123,908	9,495	56.00
60.00	06000	LABORATORY	100,339	1,775,139	115,036	1,890,175	144,838	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,856	50,520	3,274	53,794	4,122	63.00
64.00	06400	INTRAVENOUS THERAPY	2,168	38,358	2,486	40,844	3,130	64.00
65.00	06500	RESPIRATORY THERAPY	40,065	708,815	45,934	754,749	57,834	65.00
66.00	06600	PHYSICAL THERAPY	56,141	993,207	64,364	1,057,571	81,038	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	9,625	170,278	11,035	181,313	13,893	67.00
68.00	06800	SPEECH PATHOLOGY	5,234	92,595	6,001	98,596	7,555	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	437	7,725	501	8,226	630	70.00
70.01	07001	CARDIOPULMONARY	5,166	91,396	5,923	97,319	7,457	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,230	393,284	25,486	418,770	32,089	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,866	156,849	10,164	167,013	12,798	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	JV CLINIC	23,830	421,592	27,321	448,913	34,399	90.01
91.00	09100	EMERGENCY	107,564	1,902,966	123,320	2,026,286	155,268	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	36,802	651,079	0	651,079	49,890	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,302,897	22,943,701	1,362,411	22,930,848	1,637,416	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,533	0	8,533	654	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	186,300	0	186,300	14,276	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	11,211	198,337	12,853	211,190	16,183	194.02
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,314,108	23,336,871	1,375,264	23,336,871	1,668,529	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/26/2017 2:23 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT	1,623,348					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,059	126,406				8.00
9.00	00900	HOUSEKEEPING	28,153	0	659,861			9.00
10.00	01000	DIETARY	54,998	455	22,923	918,384		10.00
11.00	01100	CAFETERIA	20,019	418	8,344	563,116	485,551	11.00
13.00	01300	NURSING ADMINISTRATION	12,299	0	5,126	0	13,761	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	51,334	0	21,396	0	10,529	14.00
15.00	01500	PHARMACY	31,206	0	13,007	0	14,282	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	64,985	0	27,086	0	28,772	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	343,007	55,939	142,969	206,137	128,677	30.00
31.00	03100	INTENSIVE CARE UNIT	90,652	4,365	37,785	11,904	25,158	31.00
43.00	04300	NURSERY	7,262	3,304	3,027	0	4,691	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	293,067	16,709	122,152	7,012	38,815	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,184	734	4,245	0	556	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	123,298	7,357	51,391	0	31,066	54.00
54.01	05401	ULTRASOUND	7,414	0	3,090	0	0	54.01
56.00	05600	RADIOISOTOPE	9,159	0	3,818	0	0	56.00
60.00	06000	LABORATORY	66,076	374	27,541	0	48,857	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,143	0	1,727	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	7,349	0	3,063	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	54,692	499	22,796	0	24,880	65.00
66.00	06600	PHYSICAL THERAPY	89,671	10,724	37,375	0	34,471	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	17,904	0	7,462	0	4,274	67.00
68.00	06800	SPEECH PATHOLOGY	3,947	0	1,645	0	3,232	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,819	0	2,009	0	0	70.00
70.01	07001	CARDIOPULMONARY	25,122	0	10,471	0	2,537	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	JV CLINIC	43,047	1,712	17,942	0	15,081	90.01
91.00	09100	EMERGENCY	129,840	23,816	54,118	0	52,437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,605,706	126,406	652,508	788,169	482,076	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,492	0	4,790	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	130,215	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	6,150	0	2,563	0	3,475	194.02
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)	1,623,348	126,406	659,861	918,384	485,551	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/26/2017 2:23 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	684,800					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	341,752				14.00
15.00	01500	PHARMACY	0	6,814	1,884,412			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34	0	765,573		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	301,868	26,309	0	70,143	0	30.00
31.00	03100	INTENSIVE CARE UNIT	59,001	1,724	0	5,175	0	31.00
43.00	04300	NURSERY	11,026	1,554	0	2,193	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	90,516	32,646	0	61,990	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,287	345	0	488	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	9,364	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,866	0	143,279	0	54.00
54.01	05401	ULTRASOUND	0	0	0	25,916	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	5,120	0	56.00
60.00	06000	LABORATORY	0	33,420	0	141,598	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	8,772	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	5,387	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	15,672	0	32,134	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,008	0	19,273	0	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	45	0	4,017	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	93	0	884	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	551	0	70.00
70.01	07001	CARDIOPULMONARY	5,921	0	0	3,730	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	142,710	0	63,901	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	56,733	0	4,880	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,884,412	35,979	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	JV CLINIC	35,353	0	0	11,949	0	90.01
91.00	09100	EMERGENCY	122,730	15,102	0	101,541	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	57,098	677	0	7,309	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	684,800	341,752	1,884,412	765,573	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
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)	684,800	341,752	1,884,412	765,573	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/26/2017 2:23 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	IS/ACCOUNTING/MARKETING					5.01
5.02	00540	BUSINESS OFFICE & ADMITTING					5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,783,575	0	4,783,575		30.00
31.00	03100	INTENSIVE CARE UNIT	1,047,978	0	1,047,978		31.00
43.00	04300	NURSERY	179,434	0	179,434		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,182,532	0	2,182,532		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	45,221	0	45,221		52.00
53.00	05300	ANESTHESIOLOGY	14,013	0	14,013		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,841,939	0	1,841,939		54.00
54.01	05401	ULTRASOUND	325,737	0	325,737		54.01
56.00	05600	RADIOISOTOPE	151,500	0	151,500		56.00
60.00	06000	LABORATORY	2,352,879	0	2,352,879		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	72,558	0	72,558		63.00
64.00	06400	INTRAVENOUS THERAPY	59,773	0	59,773		64.00
65.00	06500	RESPIRATORY THERAPY	963,256	0	963,256		65.00
66.00	06600	PHYSICAL THERAPY	1,332,131	0	1,332,131		66.00
66.01	06601	SPORTS THERAPY	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	228,908	0	228,908		67.00
68.00	06800	SPEECH PATHOLOGY	115,952	0	115,952		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	16,235	0	16,235		70.00
70.01	07001	CARDIOPULMONARY	152,557	0	152,557		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	657,470	0	657,470		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	241,424	0	241,424		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,920,391	0	1,920,391		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	JV CLINIC	608,396	0	608,396		90.01
91.00	09100	EMERGENCY	2,681,138	0	2,681,138		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	766,053	0	766,053		101.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,741,050	0	22,741,050		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,469	0	25,469		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	200,576	0	200,576		192.00
192.01	19201	MSO CLINICS	0	0	0		192.01
192.03	19203	FPA	0	0	0		192.03
194.00	07950	MEALS ON WHEELS	130,215	0	130,215		194.00
194.01	07951	GUEST MEALS	0	0	0		194.01
194.02	07952	MARKETING	239,561	0	239,561		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	23,336,871	0	23,336,871		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/26/2017 2:23 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,629	5,179	8,808	8,808	4.00
5.01	00550	IS/ACCOUNTING/MARKETING	0	15,923	22,727	38,650	396	5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	0	13,421	19,156	32,577	573	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	22,007	31,410	53,417	124	5.03
7.00	00700	OPERATION OF PLANT	0	70,749	100,980	171,729	337	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,689	5,265	8,954	34	8.00
9.00	00900	HOUSEKEEPING	0	8,612	12,292	20,904	280	9.00
10.00	01000	DIETARY	0	16,823	24,012	40,835	262	10.00
11.00	01100	CAFETERIA	0	6,124	8,740	14,864	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,762	5,370	9,132	307	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	15,703	22,412	38,115	105	14.00
15.00	01500	PHARMACY	0	9,546	13,625	23,171	289	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,879	28,373	48,252	283	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	104,924	149,755	254,679	1,576	30.00
31.00	03100	INTENSIVE CARE UNIT	0	27,730	39,579	67,309	363	31.00
43.00	04300	NURSERY	0	2,221	3,170	5,391	64	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	89,647	127,953	217,600	539	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,115	4,446	7,561	8	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,716	53,832	91,548	463	54.00
54.01	05401	ULTRASOUND	0	2,268	3,237	5,505	0	54.01
56.00	05600	RADIOISOTOPE	0	2,802	3,999	6,801	0	56.00
60.00	06000	LABORATORY	0	20,212	28,849	49,061	490	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,267	1,809	3,076	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,248	3,209	5,457	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	16,730	23,879	40,609	352	65.00
66.00	06600	PHYSICAL THERAPY	0	27,430	39,150	66,580	528	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	5,477	7,817	13,294	91	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,207	1,723	2,930	52	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,474	2,104	3,578	0	70.00
70.01	07001	CARDIOPULMONARY	0	7,685	10,968	18,653	39	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	JV CLINIC	0	13,168	0	13,168	175	90.01
91.00	09100	EMERGENCY	0	39,717	56,688	96,405	680	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	341	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	616,905	861,708	1,478,613	8,751	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,515	5,018	8,533	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	1,881	2,685	4,566	57	194.02
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	622,301	869,411	1,491,712	8,808	202.00

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		Cost Center Description	IS/ACCOUNTING/ MARKETING	BUSINESS OFFICE & ADMITTING	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	IS/ACCOUNTING/MARKETING	39,046					5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	2,310	35,460				5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	2,632	2,618	58,791			5.03
7.00	00700	OPERATION OF PLANT	2,378	2,366	4,071	180,881		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	168	167	287	1,344	10,954	8.00
9.00	00900	HOUSEKEEPING	925	921	1,584	3,137	0	9.00
10.00	01000	DIETARY	1,231	1,224	2,107	6,128	39	10.00
11.00	01100	CAFETERIA	0	0	0	2,231	36	11.00
13.00	01300	NURSING ADMINISTRATION	957	953	1,639	1,370	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	379	377	648	5,720	0	14.00
15.00	01500	PHARMACY	2,665	2,652	4,562	3,477	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	944	940	1,617	7,241	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,144	5,112	8,797	38,218	4,849	30.00
31.00	03100	INTENSIVE CARE UNIT	1,190	1,184	2,037	10,101	378	31.00
43.00	04300	NURSERY	214	213	367	809	286	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,226	2,215	3,811	32,655	1,448	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	40	40	69	1,135	64	52.00
53.00	05300	ANESTHESIOLOGY	7	7	12	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,168	2,157	3,711	13,738	638	54.00
54.01	05401	ULTRASOUND	424	422	726	826	0	54.01
56.00	05600	RADIOISOTOPE	195	194	335	1,021	0	56.00
60.00	06000	LABORATORY	2,981	2,966	5,103	7,362	32	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	85	84	145	462	0	63.00
64.00	06400	INTRAVENOUS THERAPY	64	64	110	819	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,190	1,184	2,038	6,094	43	65.00
66.00	06600	PHYSICAL THERAPY	1,668	1,660	2,855	9,992	929	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	286	285	490	1,995	0	67.00
68.00	06800	SPEECH PATHOLOGY	156	155	266	440	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13	13	22	537	0	70.00
70.01	07001	CARDIOPULMONARY	153	153	263	2,799	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	660	657	1,131	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	263	262	451	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	JV CLINIC	708	704	1,212	4,797	148	90.01
91.00	09100	EMERGENCY	3,196	3,180	5,471	14,467	2,064	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,093	0	1,758	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	38,713	35,129	57,695	178,915	10,954	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	23	1,281	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	503	0	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	333	331	570	685	0	194.02
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)	39,046	35,460	58,791	180,881	10,954	202.00

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		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	27,751					9.00
10.00	01000	DIETARY	964	52,790				10.00
11.00	01100	CAFETERIA	351	32,369	39,892			11.00
13.00	01300	NURSING ADMINISTRATION	216	0	1,131	15,705		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	900	0	865	0	47,109	14.00
15.00	01500	PHARMACY	547	0	1,173	0	939	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,139	0	2,364	0	5	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,012	11,849	10,573	6,922	3,627	30.00
31.00	03100	INTENSIVE CARE UNIT	1,589	684	2,067	1,353	238	31.00
43.00	04300	NURSERY	127	0	385	253	214	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,137	403	3,189	2,076	4,500	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	179	0	46	30	48	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,161	0	2,552	0	809	54.00
54.01	05401	ULTRASOUND	130	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	161	0	0	0	0	56.00
60.00	06000	LABORATORY	1,158	0	4,014	0	4,607	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	73	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	129	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	959	0	2,044	0	2,160	65.00
66.00	06600	PHYSICAL THERAPY	1,572	0	2,832	0	277	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	314	0	351	0	6	67.00
68.00	06800	SPEECH PATHOLOGY	69	0	266	0	13	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	84	0	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	440	0	208	136	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	19,671	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	7,820	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	JV CLINIC	755	0	1,239	811	0	90.01
91.00	09100	EMERGENCY	2,276	0	4,308	2,815	2,082	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,309	93	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,442	45,305	39,607	15,705	47,109	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	201	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	7,485	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	108	0	285	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	9,959	0	0	201.00
202.00		TOTAL (sum lines 118-201)	27,751	52,790	49,851	15,705	47,109	202.00

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		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	39,475					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	62,785				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,754		363,112	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	424		88,917	0	31.00
43.00	04300	NURSERY	0	180		8,503	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,085		280,884	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	40		9,260	0	52.00
53.00	05300	ANESTHESIOLOGY	0	768		794	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,739		131,684	0	54.00
54.01	05401	ULTRASOUND	0	2,126		10,159	0	54.01
56.00	05600	RADIOISOTOPE	0	420		9,127	0	56.00
60.00	06000	LABORATORY	0	11,615		89,389	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	720		4,645	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	442		7,085	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,636		59,309	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,581		90,474	0	66.00
66.01	06601	SPORTS THERAPY	0	0		0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	330		17,442	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	72		4,419	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	45		4,292	0	70.00
70.01	07001	CARDIOPULMONARY	0	306		23,150	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,242		27,361	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	400		9,196	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,475	2,951		42,426	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		0	0	88.00
90.00	09000	CLINIC	0	0		0	0	90.00
90.01	09001	JV CLINIC	0	980		24,697	0	90.01
91.00	09100	EMERGENCY	0	8,329		145,273	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	600		5,194	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,475	62,785	0	1,456,792	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		10,038	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		503	0	192.00
192.01	19201	MSO CLINICS	0	0		0	0	192.01
192.03	19203	FPA	0	0		0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0		7,485	0	194.00
194.01	07951	GUEST MEALS	0	0		0	0	194.01
194.02	07952	MARKETING	0	0		6,935	0	194.02
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	9,959	0	201.00
202.00		TOTAL (sum lines 118-201)	39,475	62,785	0	1,491,712	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/26/2017 2:23 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	IS/ACCOUNTING/MARKETING			5.01
5.02	00540	BUSINESS OFFICE & ADMITTING			5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL			5.03
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	363,112		30.00
31.00	03100	INTENSIVE CARE UNIT	88,917		31.00
43.00	04300	NURSERY	8,503		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	280,884		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,260		52.00
53.00	05300	ANESTHESIOLOGY	794		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	131,684		54.00
54.01	05401	ULTRASOUND	10,159		54.01
56.00	05600	RADIOISOTOPE	9,127		56.00
60.00	06000	LABORATORY	89,389		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,645		63.00
64.00	06400	INTRAVENOUS THERAPY	7,085		64.00
65.00	06500	RESPIRATORY THERAPY	59,309		65.00
66.00	06600	PHYSICAL THERAPY	90,474		66.00
66.01	06601	SPORTS THERAPY	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	17,442		67.00
68.00	06800	SPEECH PATHOLOGY	4,419		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,292		70.00
70.01	07001	CARDIOPULMONARY	23,150		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,361		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,196		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,426		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0		88.00
90.00	09000	CLINIC	0		90.00
90.01	09001	JV CLINIC	24,697		90.01
91.00	09100	EMERGENCY	145,273		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	5,194		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,456,792		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,038		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	503		192.00
192.01	19201	MSO CLINICS	0		192.01
192.03	19203	FPA	0		192.03
194.00	07950	MEALS ON WHEELS	7,485		194.00
194.01	07951	GUEST MEALS	0		194.01
194.02	07952	MARKETING	6,935		194.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	9,959		201.00
202.00		TOTAL (sum lines 118-201)	1,491,712		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/26/2017 2:23 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	IS/ACCOUNTING/ MARKETING (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	93,289					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		91,315				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	544	544	11,157,772			4.00
5.01	00550	IS/ACCOUNTING/MARKETING	2,387	2,387	501,741	-1,314,108	21,934,276	5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	2,012	2,012	725,983	0	1,297,528	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	3,299	3,299	156,941	0	1,478,409	5.03
7.00	00700	OPERATION OF PLANT	10,606	10,606	426,947	0	1,336,003	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	553	553	43,177	0	94,107	8.00
9.00	00900	HOUSEKEEPING	1,291	1,291	354,583	0	519,891	9.00
10.00	01000	DIETARY	2,522	2,522	332,194	0	691,320	10.00
11.00	01100	CAFETERIA	918	918	0	106,346	0	11.00
13.00	01300	NURSING ADMINISTRATION	564	564	388,641	0	537,919	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,354	2,354	132,554	0	212,738	14.00
15.00	01500	PHARMACY	1,431	1,431	366,386	0	1,497,108	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,980	2,980	358,756	0	530,579	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,729	15,729	1,993,657	0	2,887,494	30.00
31.00	03100	INTENSIVE CARE UNIT	4,157	4,157	459,724	0	668,446	31.00
43.00	04300	NURSERY	333	333	81,151	0	120,468	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,439	13,439	683,144	0	1,250,639	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	467	467	9,711	0	22,535	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	3,826	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,654	5,654	587,332	0	1,217,766	54.00
54.01	05401	ULTRASOUND	340	340	0	0	238,105	54.01
56.00	05600	RADIOISOTOPE	420	420	0	0	109,789	56.00
60.00	06000	LABORATORY	3,030	3,030	620,781	0	1,674,800	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	190	190	0	0	47,664	63.00
64.00	06400	INTRAVENOUS THERAPY	337	337	0	0	36,190	64.00
65.00	06500	RESPIRATORY THERAPY	2,508	2,508	446,137	0	668,750	65.00
66.00	06600	PHYSICAL THERAPY	4,112	4,112	668,892	0	937,066	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	821	821	114,703	0	160,653	67.00
68.00	06800	SPEECH PATHOLOGY	181	181	65,764	0	87,361	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	221	221	0	0	7,288	70.00
70.01	07001	CARDIOPULMONARY	1,152	1,152	49,224	0	86,230	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	371,054	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	147,983	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	JV CLINIC	1,974	0	221,871	0	397,762	90.01
91.00	09100	EMERGENCY	5,954	5,954	862,424	0	1,795,402	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	432,546	0	614,277	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	92,480	90,506	11,084,964	-1,207,762	21,747,150	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	527	527	0	-8,533	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	-186,300	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	282	282	72,808	0	187,126	194.02
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)	622,301	869,411	3,051,087		1,314,108	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.670679	9.521010	0.273449		0.059911	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			8,808		39,046	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000789		0.001780	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/26/2017 2:23 pm

		Cost Center Description	Reconciliation	BUSINESS OFFICE & ADMITTING (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5A.02	5.02	5A.03	5.03	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	-1,375,264	21,222,041				5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	1,566,982	-1,668,529	21,774,688		5.03
7.00	00700	OPERATION OF PLANT	0	1,416,044	0	1,507,809	74,441	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	99,745	0	106,209	553	8.00
9.00	00900	HOUSEKEEPING	0	551,038	0	586,747	1,291	9.00
10.00	01000	DIETARY	0	732,738	0	780,222	2,522	10.00
11.00	01100	CAFETERIA	106,346	0	106,346	0	918	11.00
13.00	01300	NURSING ADMINISTRATION	0	570,146	0	607,094	564	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	225,483	0	240,095	2,354	14.00
15.00	01500	PHARMACY	0	1,586,801	0	1,689,632	1,431	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	562,367	0	598,811	2,980	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,060,491	0	3,258,813	15,729	30.00
31.00	03100	INTENSIVE CARE UNIT	0	708,493	0	754,406	4,157	31.00
43.00	04300	NURSERY	0	127,685	0	135,959	333	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,325,566	0	1,411,468	13,439	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	23,885	0	25,433	467	52.00
53.00	05300	ANESTHESIOLOGY	0	4,055	0	4,318	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,290,724	0	1,374,368	5,654	54.00
54.01	05401	ULTRASOUND	0	252,370	0	268,725	340	54.01
56.00	05600	RADIOISOTOPE	0	116,367	0	123,908	420	56.00
60.00	06000	LABORATORY	0	1,775,139	0	1,890,175	3,030	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	50,520	0	53,794	190	63.00
64.00	06400	INTRAVENOUS THERAPY	0	38,358	0	40,844	337	64.00
65.00	06500	RESPIRATORY THERAPY	0	708,815	0	754,749	2,508	65.00
66.00	06600	PHYSICAL THERAPY	0	993,207	0	1,057,571	4,112	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	170,278	0	181,313	821	67.00
68.00	06800	SPEECH PATHOLOGY	0	92,595	0	98,596	181	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,725	0	8,226	221	70.00
70.01	07001	CARDIOPULMONARY	0	91,396	0	97,319	1,152	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	393,284	0	418,770	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	156,849	0	167,013	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	JV CLINIC	0	421,592	0	448,913	1,974	90.01
91.00	09100	EMERGENCY	0	1,902,966	0	2,026,286	5,954	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	-651,079	0	0	651,079	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,919,997	21,023,704	-1,562,183	21,368,665	73,632	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-8,533	0	0	8,533	527	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-186,300	0	0	186,300	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	198,337	0	211,190	282	194.02
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)		1,375,264		1,668,529	1,623,348	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.064804		0.076627	21.807176	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		35,460		58,791	180,881	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001671		0.002700	2.429857	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/26/2017 2:23 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	118,251					8.00
9.00	00900	HOUSEKEEPING	0	72,597				9.00
10.00	01000	DIETARY	426	2,522	60,640			10.00
11.00	01100	CAFETERIA	391	918	37,182	13,973		11.00
13.00	01300	NURSING ADMINISTRATION	0	564	0	396	174,528	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,354	0	303	0	14.00
15.00	01500	PHARMACY	0	1,431	0	411	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,980	0	828	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,329	15,729	13,611	3,703	76,934	30.00
31.00	03100	INTENSIVE CARE UNIT	4,083	4,157	786	724	15,037	31.00
43.00	04300	NURSERY	3,091	333	0	135	2,810	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,631	13,439	463	1,117	23,069	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	687	467	0	16	328	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,882	5,654	0	894	0	54.00
54.01	05401	ULTRASOUND	0	340	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	420	0	0	0	56.00
60.00	06000	LABORATORY	350	3,030	0	1,406	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	190	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	337	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	467	2,508	0	716	0	65.00
66.00	06600	PHYSICAL THERAPY	10,032	4,112	0	992	0	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	821	0	123	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	181	0	93	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	221	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	0	1,152	0	73	1,509	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	JV CLINIC	1,602	1,974	0	434	9,010	90.01
91.00	09100	EMERGENCY	22,280	5,954	0	1,509	31,279	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	14,552	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	118,251	71,788	52,042	13,873	174,528	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	527	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	8,598	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	282	0	100	0	194.02
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)	126,406	659,861	918,384	485,551	684,800	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.068963	9.089370	15.144855	34.749231	3.923726	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,954	27,751	52,790	49,851	15,705	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.092633	0.382261	0.870547	2.854935	0.089986	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/26/2017 2:23 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			14.00	15.00	16.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	891,432					14.00
15.00	01500	PHARMACY	17,774	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	89	0	69,237,442			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	68,625	0	6,343,791	0		30.00
31.00	03100	INTENSIVE CARE UNIT	4,496	0	467,997	0		31.00
43.00	04300	NURSERY	4,054	0	198,360	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	85,154	0	5,606,446	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	901	0	44,090	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	846,876	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,302	0	12,956,876	0		54.00
54.01	05401	ULTRASOUND	0	0	2,343,823	0		54.01
56.00	05600	RADIOISOTOPE	0	0	463,028	0		56.00
60.00	06000	LABORATORY	87,173	0	12,806,193	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	793,342	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	487,206	0		64.00
65.00	06500	RESPIRATORY THERAPY	40,878	0	2,906,219	0		65.00
66.00	06600	PHYSICAL THERAPY	5,237	0	1,743,033	0		66.00
66.01	06601	SPORTS THERAPY	0	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	118	0	363,312	0		67.00
68.00	06800	SPEECH PATHOLOGY	243	0	79,911	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	49,835	0		70.00
70.01	07001	CARDIOPULMONARY	0	0	337,338	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	372,247	0	5,779,262	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	147,983	0	441,360	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	3,253,959	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	JV CLINIC	0	0	1,080,708	0		90.01
91.00	09100	EMERGENCY	39,393	0	9,183,405	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,765	0	661,072	0		101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	891,432	100	69,237,442	0		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	MSO CLINICS	0	0	0	0		192.01
192.03	19203	FPA	0	0	0	0		192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0		194.00
194.01	07951	GUEST MEALS	0	0	0	0		194.01
194.02	07952	MARKETING	0	0	0	0		194.02
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)	341,752	1,884,412	765,573	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.383374	18,844.120000	0.011057	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	47,109	39,475	62,785	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.052846	394.750000	0.000907	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/26/2017 2:23 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	4,783,575		4,783,575	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,047,978		1,047,978	0	0	31.00
43.00	04300	NURSERY	179,434		179,434	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,182,532		2,182,532	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	45,221		45,221	0	0	52.00
53.00	05300	ANESTHESIOLOGY	14,013		14,013	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,841,939		1,841,939	0	0	54.00
54.01	05401	ULTRASOUND	325,737		325,737	0	0	54.01
56.00	05600	RADIOISOTOPE	151,500		151,500	0	0	56.00
60.00	06000	LABORATORY	2,352,879		2,352,879	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	72,558		72,558	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	59,773		59,773	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	963,256	0	963,256	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,332,131	0	1,332,131	0	0	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	228,908	0	228,908	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	115,952	0	115,952	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	16,235		16,235	0	0	70.00
70.01	07001	CARDIOPULMONARY	152,557		152,557	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	657,470		657,470	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	241,424		241,424	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,920,391		1,920,391	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	JV CLINIC	608,396		608,396	0	0	90.01
91.00	09100	EMERGENCY	2,681,138		2,681,138	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,095,872		2,095,872		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	766,053		766,053		0	101.00
200.00		Subtotal (see instructions)	24,836,922	0	24,836,922	0	0	200.00
201.00		Less Observation Beds	2,095,872		2,095,872		0	201.00
202.00		Total (see instructions)	22,741,050	0	22,741,050	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/26/2017 2:23 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	3,367,131		3,367,131			30.00
31.00	03100	INTENSIVE CARE UNIT	467,997		467,997			31.00
43.00	04300	NURSERY	198,360		198,360			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	804,659	4,801,787	5,606,446	0.389290	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,962	31,128	44,090	1.025652	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	142,737	704,139	846,876	0.016547	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	258,563	12,698,313	12,956,876	0.142159	0.000000	54.00
54.01	05401	ULTRASOUND	184,456	2,159,367	2,343,823	0.138977	0.000000	54.01
56.00	05600	RADIOISOTOPE	23,714	439,314	463,028	0.327194	0.000000	56.00
60.00	06000	LABORATORY	617,948	12,188,245	12,806,193	0.183730	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	361,256	432,086	793,342	0.091459	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	150,599	336,607	487,206	0.122685	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	881,805	2,024,414	2,906,219	0.331446	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	117,597	1,625,436	1,743,033	0.764260	0.000000	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0.000000	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,146	360,166	363,312	0.630059	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	8,353	71,558	79,911	1.451014	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,902	47,933	49,835	0.325775	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0	337,338	337,338	0.452238	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,909,228	3,870,034	5,779,262	0.113764	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	102,501	338,859	441,360	0.547000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	889,717	2,364,242	3,253,959	0.590171	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	JV CLINIC	0	1,080,708	1,080,708	0.562961	0.000000	90.01
91.00	09100	EMERGENCY	43,761	9,139,644	9,183,405	0.291955	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	63,199	2,913,461	2,976,660	0.704102	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	661,072	661,072			101.00
200.00		Subtotal (see instructions)	10,611,591	58,625,851	69,237,442			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,611,591	58,625,851	69,237,442			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/26/2017 2:23 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
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
66.01	06601	SPORTS THERAPY	0.000000		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001	CARDIOPULMONARY	0.000000		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	JV CLINIC	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
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: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/26/2017 2:23 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,783,575		4,783,575	0	4,783,575	30.00
31.00	03100	INTENSIVE CARE UNIT	1,047,978		1,047,978	0	1,047,978	31.00
43.00	04300	NURSERY	179,434		179,434	0	179,434	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,182,532		2,182,532	0	2,182,532	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	45,221		45,221	0	45,221	52.00
53.00	05300	ANESTHESIOLOGY	14,013		14,013	0	14,013	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,841,939		1,841,939	0	1,841,939	54.00
54.01	05401	ULTRASOUND	325,737		325,737	0	325,737	54.01
56.00	05600	RADIOISOTOPE	151,500		151,500	0	151,500	56.00
60.00	06000	LABORATORY	2,352,879		2,352,879	0	2,352,879	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	72,558		72,558	0	72,558	63.00
64.00	06400	INTRAVENOUS THERAPY	59,773		59,773	0	59,773	64.00
65.00	06500	RESPIRATORY THERAPY	963,256	0	963,256	0	963,256	65.00
66.00	06600	PHYSICAL THERAPY	1,332,131	0	1,332,131	0	1,332,131	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	228,908	0	228,908	0	228,908	67.00
68.00	06800	SPEECH PATHOLOGY	115,952	0	115,952	0	115,952	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	16,235		16,235	0	16,235	70.00
70.01	07001	CARDIOPULMONARY	152,557		152,557	0	152,557	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	657,470		657,470	0	657,470	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	241,424		241,424	0	241,424	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,920,391		1,920,391	0	1,920,391	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	JV CLINIC	608,396		608,396	0	608,396	90.01
91.00	09100	EMERGENCY	2,681,138		2,681,138	0	2,681,138	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,095,872		2,095,872		2,095,872	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	766,053		766,053		766,053	101.00
200.00		Subtotal (see instructions)	24,836,922	0	24,836,922	0	24,836,922	200.00
201.00		Less Observation Beds	2,095,872		2,095,872		2,095,872	201.00
202.00		Total (see instructions)	22,741,050	0	22,741,050	0	22,741,050	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/26/2017 2:23 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	3,367,131		3,367,131			30.00
31.00	03100	INTENSIVE CARE UNIT	467,997		467,997			31.00
43.00	04300	NURSERY	198,360		198,360			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	804,659	4,801,787	5,606,446	0.389290	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,962	31,128	44,090	1.025652	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	142,737	704,139	846,876	0.016547	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	258,563	12,698,313	12,956,876	0.142159	0.000000	54.00
54.01	05401	ULTRASOUND	184,456	2,159,367	2,343,823	0.138977	0.000000	54.01
56.00	05600	RADIOISOTOPE	23,714	439,314	463,028	0.327194	0.000000	56.00
60.00	06000	LABORATORY	617,948	12,188,245	12,806,193	0.183730	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	361,256	432,086	793,342	0.091459	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	150,599	336,607	487,206	0.122685	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	881,805	2,024,414	2,906,219	0.331446	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	117,597	1,625,436	1,743,033	0.764260	0.000000	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0.000000	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,146	360,166	363,312	0.630059	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	8,353	71,558	79,911	1.451014	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,902	47,933	49,835	0.325775	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0	337,338	337,338	0.452238	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,909,228	3,870,034	5,779,262	0.113764	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	102,501	338,859	441,360	0.547000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	889,717	2,364,242	3,253,959	0.590171	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	JV CLINIC	0	1,080,708	1,080,708	0.562961	0.000000	90.01
91.00	09100	EMERGENCY	43,761	9,139,644	9,183,405	0.291955	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	63,199	2,913,461	2,976,660	0.704102	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	661,072	661,072			101.00
200.00		Subtotal (see instructions)	10,611,591	58,625,851	69,237,442			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,611,591	58,625,851	69,237,442			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/26/2017 2:23 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
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
66.01	06601	SPORTS THERAPY	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	JV CLINIC	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
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: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/26/2017 2:23 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	280,884	5,606,446	0.050100	299,900	15,025	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,260	44,090	0.210025	0	0	52.00
53.00	05300	ANESTHESIOLOGY	794	846,876	0.000938	58,846	55	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	131,684	12,956,876	0.010163	225,154	2,288	54.00
54.01	05401	ULTRASOUND	10,159	2,343,823	0.004334	114,182	495	54.01
56.00	05600	RADIOISOTOPE	9,127	463,028	0.019712	17,129	338	56.00
60.00	06000	LABORATORY	89,389	12,806,193	0.006980	496,816	3,468	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,645	793,342	0.005855	217,245	1,272	63.00
64.00	06400	INTRAVENOUS THERAPY	7,085	487,206	0.014542	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	59,309	2,906,219	0.020408	328,264	6,699	65.00
66.00	06600	PHYSICAL THERAPY	90,474	1,743,033	0.051906	37,475	1,945	66.00
66.01	06601	SPORTS THERAPY	0	0	0.000000	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	17,442	363,312	0.048008	911	44	67.00
68.00	06800	SPEECH PATHOLOGY	4,419	79,911	0.055299	5,551	307	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,292	49,835	0.086124	1,902	164	70.00
70.01	07001	CARDIOPULMONARY	23,150	337,338	0.068626	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,361	5,779,262	0.004734	839,337	3,973	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,196	441,360	0.020836	59,707	1,244	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,426	3,253,959	0.013038	576,181	7,512	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	JV CLINIC	24,697	1,080,708	0.022853	0	0	90.01
91.00	09100	EMERGENCY	145,273	9,183,405	0.015819	24,714	391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	159,093	2,976,660	0.053447	4,292	229	92.00
200.00		Total (lines 50-199)	1,150,159	64,542,882		3,307,606	45,449	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/26/2017 2:23 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
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	JV CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/26/2017 2:23 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	5,606,446	0.000000	0.000000	299,900	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	44,090	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	846,876	0.000000	0.000000	58,846	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,956,876	0.000000	0.000000	225,154	54.00
54.01	05401	ULTRASOUND	0	2,343,823	0.000000	0.000000	114,182	54.01
56.00	05600	RADIOISOTOPE	0	463,028	0.000000	0.000000	17,129	56.00
60.00	06000	LABORATORY	0	12,806,193	0.000000	0.000000	496,816	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	793,342	0.000000	0.000000	217,245	63.00
64.00	06400	INTRAVENOUS THERAPY	0	487,206	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,906,219	0.000000	0.000000	328,264	65.00
66.00	06600	PHYSICAL THERAPY	0	1,743,033	0.000000	0.000000	37,475	66.00
66.01	06601	SPORTS THERAPY	0	0	0.000000	0.000000	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	363,312	0.000000	0.000000	911	67.00
68.00	06800	SPEECH PATHOLOGY	0	79,911	0.000000	0.000000	5,551	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	49,835	0.000000	0.000000	1,902	70.00
70.01	07001	CARDIOPULMONARY	0	337,338	0.000000	0.000000	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,779,262	0.000000	0.000000	839,337	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	441,360	0.000000	0.000000	59,707	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,253,959	0.000000	0.000000	576,181	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	JV CLINIC	0	1,080,708	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	9,183,405	0.000000	0.000000	24,714	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,976,660	0.000000	0.000000	4,292	92.00
200.00		Total (lines 50-199)	0	64,542,882			3,307,606	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/26/2017 2:23 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
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
66.01	06601	SPORTS THERAPY	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
70.01	07001	CARDIOPULMONARY	0	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	JV CLINIC	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/26/2017 2:23 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	0.389290	0	1,265,295	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.025652	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016547	0	208,405	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142159	0	4,329,830	0	0	54.00
54.01	05401	ULTRASOUND	0.138977	0	512,324	0	0	54.01
56.00	05600	RADIOISOTOPE	0.327194	0	208,637	0	0	56.00
60.00	06000	LABORATORY	0.183730	0	4,603,641	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.091459	0	137,150	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.122685	0	329,983	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.331446	0	502,218	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.764260	0	555,811	0	0	66.00
66.01	06601	SPORTS THERAPY	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.630059	0	96,268	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.451014	0	5,148	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.325775	0	5,426	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.452238	0	184,249	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.113764	0	1,406,374	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.547000	0	91,230	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.590171	0	821,299	51,108	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	JV CLINIC	0.562961	0	312,820	0	0	90.01
91.00	09100	EMERGENCY	0.291955	0	2,914,710	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.704102	0	1,210,966	0	0	92.00
200.00		Subtotal (see instructions)		0	19,701,784	51,108	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	19,701,784	51,108	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/26/2017 2:23 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	492,567	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	3,448	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	615,524	0		54.00
54.01	05401	ULTRASOUND	71,201	0		54.01
56.00	05600	RADIOISOTOPE	68,265	0		56.00
60.00	06000	LABORATORY	845,827	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,544	0		63.00
64.00	06400	INTRAVENOUS THERAPY	40,484	0		64.00
65.00	06500	RESPIRATORY THERAPY	166,458	0		65.00
66.00	06600	PHYSICAL THERAPY	424,784	0		66.00
66.01	06601	SPORTS THERAPY	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	60,655	0		67.00
68.00	06800	SPEECH PATHOLOGY	7,470	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,768	0		70.00
70.01	07001	CARDIOPULMONARY	83,324	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	159,995	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	49,903	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	484,707	30,162		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	JV CLINIC	176,105	0		90.01
91.00	09100	EMERGENCY	850,964	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	852,644	0		92.00
200.00		Subtotal (see instructions)	5,468,637	30,162		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,468,637	30,162		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1327 | Component CCN: 15-Z327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 5/26/2017 2:23 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	0.389290	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.025652	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016547	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142159	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.138977	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.327194	0	0	0	0	56.00
60.00	06000	LABORATORY	0.183730	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.091459	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.122685	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.331446	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.764260	0	0	0	0	66.00
66.01	06601	SPORTS THERAPY	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.630059	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.451014	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.325775	0	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.452238	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.113764	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.547000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.590171	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	JV CLINIC	0.562961	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.291955	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.704102	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: 15-1327 | Component CCN: 15-Z327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 5/26/2017 2:23 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
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
66.01	06601	SPORTS THERAPY	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	CARDIOPULMONARY	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	JV CLINIC	0	0		90.01
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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/26/2017 2:23 pm

Title XIX | 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	0.389290	0	60,233	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.025652	0	3,042	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016547	0	24,165	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142159	0	219,806	0	0	54.00
54.01	05401	ULTRASOUND	0.138977	0	67,995	0	0	54.01
56.00	05600	RADIOISOTOPE	0.327194	0	3,540	0	0	56.00
60.00	06000	LABORATORY	0.183730	0	194,511	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.091459	0	3,870	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.122685	0	5,854	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.331446	0	20,133	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.764260	0	12,335	0	0	66.00
66.01	06601	SPORTS THERAPY	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.630059	0	4,352	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.451014	0	4,381	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.325775	0	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.452238	0	594	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.113764	0	98,348	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.547000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.590171	0	23,075	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	JV CLINIC	0.562961	0	1,729	0	0	90.01
91.00	09100	EMERGENCY	0.291955	0	59,781	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.704102	0	59,669	0	0	92.00
200.00		Subtotal (see instructions)		0	867,413	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	867,413	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/26/2017 2:23 pm

Title XIX | 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	23,448	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,120	0	52.00
53.00	05300	ANESTHESIOLOGY	400	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,247	0	54.00
54.01	05401	ULTRASOUND	9,450	0	54.01
56.00	05600	RADIOISOTOPE	1,158	0	56.00
60.00	06000	LABORATORY	35,738	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	354	0	63.00
64.00	06400	INTRAVENOUS THERAPY	718	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,673	0	65.00
66.00	06600	PHYSICAL THERAPY	9,427	0	66.00
66.01	06601	SPORTS THERAPY	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	2,742	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,357	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	CARDIOPULMONARY	269	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,188	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,618	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	JV CLINIC	973	0	90.01
91.00	09100	EMERGENCY	17,453	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	42,013	0	92.00
200.00		Subtotal (see instructions)	216,346	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	216,346	0	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1327	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/26/2017 2:23 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)	4,494	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,028	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,096	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	361	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	105	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,261	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)	361	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	212.56	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)	4,783,575	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)	22,319	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)	413,939	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,369,636	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,369,636	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)	1,084.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,367,958	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)	1,367,958	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 2:23 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	1,047,978	205	5,112.09	126	644,123	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)	907,473	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,919,554	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)	391,620	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)	391,620	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)	1,932	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,084.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,095,872	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 2:23 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	363,112	4,783,575	0.075908	2,095,872	159,093	90.00
91.00	Nursing School cost	0	4,783,575	0.000000	2,095,872	0	91.00
92.00	Allied health cost	0	4,783,575	0.000000	2,095,872	0	92.00
93.00	All other Medical Education	0	4,783,575	0.000000	2,095,872	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 2:23 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)	4,494	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,028	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,096	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	361	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	105	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)	70	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)	232	15.00
16.00	Nursery days (title V or XIX only)	150	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	212.56	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)	4,783,575	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)	22,319	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)	413,939	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,369,636	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,369,636	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)	1,084.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	75,937	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)	75,937	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 2:23 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)	179,434	232	773.42	150	116,013	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,047,978	205	5,112.09	15	76,681	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)	67,338	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	335,969	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)	1,932	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,084.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,095,872	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 2:23 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	363,112	4,783,575	0.075908	2,095,872	159,093	90.00
91.00	Nursing School cost	0	4,783,575	0.000000	2,095,872	0	91.00
92.00	Allied health cost	0	4,783,575	0.000000	2,095,872	0	92.00
93.00	All other Medical Education	0	4,783,575	0.000000	2,095,872	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/26/2017 2:23 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		1,773,577		30.00
31.00	03100	INTENSIVE CARE UNIT		288,070		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.389290	299,900	116,748	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.025652	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016547	58,846	974	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142159	225,154	32,008	54.00
54.01	05401	ULTRASOUND	0.138977	114,182	15,869	54.01
56.00	05600	RADIOISOTOPE	0.327194	17,129	5,605	56.00
60.00	06000	LABORATORY	0.183730	496,816	91,280	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.091459	217,245	19,869	63.00
64.00	06400	INTRAVENOUS THERAPY	0.122685	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.331446	328,264	108,802	65.00
66.00	06600	PHYSICAL THERAPY	0.764260	37,475	28,641	66.00
66.01	06601	SPORTS THERAPY	0.000000	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.630059	911	574	67.00
68.00	06800	SPEECH PATHOLOGY	1.451014	5,551	8,055	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.325775	1,902	620	70.00
70.01	07001	CARDIOPULMONARY	0.452238	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.113764	839,337	95,486	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.547000	59,707	32,660	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.590171	576,181	340,045	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	JV CLINIC	0.562961	0	0	90.01
91.00	09100	EMERGENCY	0.291955	24,714	7,215	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.704102	4,292	3,022	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,307,606	907,473	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,307,606		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1327 | Component CCN: 15-Z327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/26/2017 2:23 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	0.389290	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.025652	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016547	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142159	15,088	2,145	54.00
54.01	05401	ULTRASOUND	0.138977	1,421	197	54.01
56.00	05600	RADIOISOTOPE	0.327194	0	0	56.00
60.00	06000	LABORATORY	0.183730	56,833	10,442	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.091459	4,874	446	63.00
64.00	06400	INTRAVENOUS THERAPY	0.122685	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.331446	53,648	17,781	65.00
66.00	06600	PHYSICAL THERAPY	0.764260	47,021	35,936	66.00
66.01	06601	SPORTS THERAPY	0.000000	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.630059	1,989	1,253	67.00
68.00	06800	SPEECH PATHOLOGY	1.451014	434	630	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.325775	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.452238	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.113764	62,560	7,117	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.547000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.590171	120,073	70,864	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	JV CLINIC	0.562961	0	0	90.01
91.00	09100	EMERGENCY	0.291955	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.704102	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		363,941	146,811	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)		363,941		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/26/2017 2:23 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		69,871		30.00
31.00	03100	INTENSIVE CARE UNIT		8,314		31.00
43.00	04300	NURSERY		23,085		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.389290	33,465	13,028	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.025652	912	935	52.00
53.00	05300	ANESTHESIOLOGY	0.016547	32,502	538	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142159	17,669	2,512	54.00
54.01	05401	ULTRASOUND	0.138977	6,940	965	54.01
56.00	05600	RADIOISOTOPE	0.327194	1,283	420	56.00
60.00	06000	LABORATORY	0.183730	27,237	5,004	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.091459	10,218	935	63.00
64.00	06400	INTRAVENOUS THERAPY	0.122685	3,554	436	64.00
65.00	06500	RESPIRATORY THERAPY	0.331446	16,735	5,547	65.00
66.00	06600	PHYSICAL THERAPY	0.764260	858	656	66.00
66.01	06601	SPORTS THERAPY	0.000000	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.630059	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.451014	282	409	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.325775	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.452238	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.113764	91,657	10,427	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.547000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.590171	25,361	14,967	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	JV CLINIC	0.562961	0	0	90.01
91.00	09100	EMERGENCY	0.291955	18,826	5,496	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.704102	7,191	5,063	92.00
200.00		Total (sum of lines 50-94 and 96-98)		294,690	67,338	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)		294,690		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1327	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/26/2017 2:23 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,498,799	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,498,799	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,553,787	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)	33,078	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,998,840	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)	2,521,869	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)	2,521,869	30.00
31.00	Primary payer payments	3,637	31.00
32.00	Subtotal (line 30 minus line 31)	2,518,232	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)	834,084	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	542,155	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	693,597	36.00
37.00	Subtotal (see instructions)	3,060,387	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)	3,060,387	40.00
40.01	Sequestration adjustment (see instructions)	61,208	40.01
41.00	Interim payments	3,064,025	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-64,846	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: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 5/26/2017 2:23 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		2,420,781		3,064,025	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,420,781		3,064,025	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		223,844		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		64,846	6.02
7.00	Total Medicare program liability (see instructions)		2,644,625		2,999,179	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: 15-1327 | Component CCN: 15-Z327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2017 2:23 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		498,419		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		498,419		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		33,415		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		531,834		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: 15-1327	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/26/2017 2:23 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	763	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,387	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	159	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,301	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	69,237,442	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	6,909,767	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: 15-1327 | Component CCN: 15-Z327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-2 | Date/Time Prepared: 5/26/2017 2:23 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)	395,536	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)	148,279	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	361	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)	543,815	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	543,815	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)	543,815	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,127	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)	542,688	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)	542,688	0	19.00
19.01	Sequestration adjustment (see instructions)	10,854	0	19.01
20.00	Interim payments	498,419	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)	33,415	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1327	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part V Date/Time Prepared: 5/26/2017 2:23 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,919,554	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)	2,919,554	4.00
5.00	Primary payer payments	1,176	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,947,574	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)	2,947,574	19.00
20.00	Deductibles (exclude professional component)	399,224	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,548,350	22.00
23.00	Coinsurance	2,254	23.00
24.00	Subtotal (line 22 minus line 23)	2,546,096	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	234,617	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	152,501	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	38,315	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,698,597	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)	2,698,597	30.00
30.01	Sequestration adjustment (see instructions)	53,972	30.01
31.00	Interim payments	2,420,781	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)	223,844	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: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-3 Part VII Date/Time Prepared: 5/26/2017 2:23 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	335,969		1.00
2.00	Medical and other services		216,346	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	335,969	216,346	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)	335,969	216,346	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	294,690	867,413	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)	294,690	867,413	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)	294,690	867,413	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	651,067	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	41,279	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)	335,969	216,346	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)	335,969	216,346	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	41,279	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	335,969	216,346	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)	335,969	216,346	36.00
37.00	OTHER	-335,969	-216,346	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/26/2017 2:23 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	3,821,218	0	0	0	1.00
2.00	Temporary investments	11,091,706	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,713,977	0	0	0	4.00
5.00	Other receivable	1,114,943	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,745,005	0	0	0	6.00
7.00	Inventory	543,563	0	0	0	7.00
8.00	Prepaid expenses	409,238	0	0	0	8.00
9.00	Other current assets	0	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)	19,949,640	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,042,227	0	0	0	12.00
13.00	Land improvements	345,187	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	18,140,589	0	0	0	15.00
16.00	Accumulated depreciation	-24,530,335	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	1,104,418	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	17,604,289	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,706,375	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	33,656,015	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,203,640	0	0	0	37.00
38.00	Salaries, wages, and fees payable	312,920	0	0	0	38.00
39.00	Payroll taxes payable	595,239	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,495,159	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,606,958	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,606,958	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	30,049,057				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)	30,049,057	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	33,656,015	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/26/2017 2:23 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		30,281,018		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,038,106				2.00
3.00	Total (sum of line 1 and line 2)		31,319,124		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		31,319,124		0		11.00
12.00	LOSS PROFIT/LOSS CLEARING	1,270,067		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)		1,270,067		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		30,049,057		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	LOSS PROFIT/LOSS CLEARING		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: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2017 2:23 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,201,705		3,201,705	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	354,626		354,626	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)	3,556,331		3,556,331	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	542,201		542,201	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)	542,201		542,201	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,098,532		4,098,532	17.00
18.00	Ancillary services	7,111,116	59,257,193	66,368,309	18.00
19.00	Outpatient services	0	0	0	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		698,847	698,847	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				26.00
27.00	OTHER REVENUE	0	-37,775	-37,775	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,209,648	59,918,265	71,127,913	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,679,594		29.00
30.00	EXPENSES NOT INCLUDED ON WORKSHEET A	1,926,586			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)		1,926,586		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)		27,606,180		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1327 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-3 | Date/Time Prepared: 5/26/2017 2:23 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	71,127,913	1.00
2.00	Less contractual allowances and discounts on patients' accounts	42,640,956	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,486,957	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,606,180	4.00
5.00	Net income from service to patients (line 3 minus line 4)	880,777	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	55	6.00
7.00	Income from investments	52,262	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	139,592	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	1,193	16.00
17.00	Revenue from sale of drugs to other than patients	301	17.00
18.00	Revenue from sale of medical records and abstracts	6,966	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	-107	21.00
22.00	Rental of hospital space	750	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER	-43,683	24.00
25.00	Total other income (sum of lines 6-24)	157,329	25.00
26.00	Total (line 5 plus line 25)	1,038,106	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)	1,038,106	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1327 HHA CCN: 15-7542 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H | Date/Time Prepared: 5/26/2017 2:23 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	103,657	0	5,921	0	38,745	148,323	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	129,212	0	7,381	0	0	136,593	6.00
7.00	Physical Therapy	135,123	0	7,718	0	0	142,841	7.00
8.00	Occupational Therapy	36,807	0	2,102	0	0	38,909	8.00
9.00	Speech Pathology	2,832	0	162	0	0	2,994	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	24,915	0	1,423	0	0	26,338	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)	432,546	0	24,707	0	38,745	495,998	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	148,323	0	148,323			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	136,593	0	136,593			6.00
7.00	Physical Therapy	0	142,841	0	142,841			7.00
8.00	Occupational Therapy	0	38,909	0	38,909			8.00
9.00	Speech Pathology	0	2,994	0	2,994			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	26,338	0	26,338			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)	0	495,998	0	495,998			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: 15-1327
HHA CCN: 15-7542

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

Worksheet H-1 Part I
Date/Time Prepared: 5/26/2017 2:23 pm

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	148,323	0	0	0	0	148,323	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	136,593	0	0	0	0	136,593	6.00
7.00	Physical Therapy	142,841	0	0	0	0	142,841	7.00
8.00	Occupational Therapy	38,909	0	0	0	0	38,909	8.00
9.00	Speech Pathology	2,994	0	0	0	0	2,994	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	26,338	0	0	0	0	26,338	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)	495,998	0	0	0	0	495,998	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	148,323		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	58,272	194,865	6.00
7.00	Physical Therapy	60,939	203,780	7.00
8.00	Occupational Therapy	16,599	55,508	8.00
9.00	Speech Pathology	1,277	4,271	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	11,236	37,574	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)		495,998	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-1327 HHA CCN: 15-7542 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-1 Part II Date/Time Prepared: 5/26/2017 2:23 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	-148,323	347,675	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	136,593	6.00
7.00	Physical Therapy	0	0	0	0	0	142,841	7.00
8.00	Occupational Therapy	0	0	0	0	0	38,909	8.00
9.00	Speech Pathology	0	0	0	0	0	2,994	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	26,338	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	-148,323	347,675	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		148,323	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.426614	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1327 HHA CCN: 15-7542

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

Worksheet H-2 Part I Date/Time Prepared: 5/26/2017 2:23 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	IS/ACCOUNTING/ MARKETING	
		0	1.00	2.00	4.00	4A	5.01	
1.00	Administrative and General	0	0	0	118,279	118,279	7,086	1.00
2.00	Skilled Nursing Care	194,865	0	0	0	194,865	11,675	2.00
3.00	Physical Therapy	203,780	0	0	0	203,780	12,208	3.00
4.00	Occupational Therapy	55,508	0	0	0	55,508	3,326	4.00
5.00	Speech Pathology	4,271	0	0	0	4,271	256	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	37,574	0	0	0	37,574	2,251	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)	495,998	0	0	118,279	614,277	36,802	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	Subtotal	BUSINESS OFFICE & ADMITTING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5A.01	5.02	5A.02	5.03	7.00	8.00	
1.00	Administrative and General	125,365	0	125,365	9,606	0	0	1.00
2.00	Skilled Nursing Care	206,540	0	206,540	15,827	0	0	2.00
3.00	Physical Therapy	215,988	0	215,988	16,550	0	0	3.00
4.00	Occupational Therapy	58,834	0	58,834	4,508	0	0	4.00
5.00	Speech Pathology	4,527	0	4,527	347	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	39,825	0	39,825	3,052	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)	651,079	0	651,079	49,890	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.	0.000000		0.000000				21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1327 | HHA CCN: 15-7542 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-2 Part I | Date/Time Prepared: 5/26/2017 2:23 pm

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	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	57,098	677	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	0	0	57,098	677	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		16.00	19.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	7,309	0	200,055	0	200,055		1.00
2.00	Skilled Nursing Care	0	0	222,367	0	222,367	78,597	2.00
3.00	Physical Therapy	0	0	232,538	0	232,538	82,191	3.00
4.00	Occupational Therapy	0	0	63,342	0	63,342	22,389	4.00
5.00	Speech Pathology	0	0	4,874	0	4,874	1,723	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	42,877	0	42,877	15,155	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)	7,309	0	766,053	0	766,053	200,055	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.						0.353455	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: 15-1327
HHA CCN: 15-7542

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

Worksheet H-2 Part I
Date/Time Prepared: 5/26/2017 2:23 pm

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	Cost Center Description	Total HHA Costs				
		28.00				
1.00	Administrative and General					1.00
2.00	Skilled Nursing Care	300,964				2.00
3.00	Physical Therapy	314,729				3.00
4.00	Occupational Therapy	85,731				4.00
5.00	Speech Pathology	6,597				5.00
6.00	Medical Social Services	0				6.00
7.00	Home Health Aide	58,032				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)	766,053				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: 15-1327 HHA CCN: 15-7542

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

Worksheet H-2 Part II Date/Time Prepared: 5/26/2017 2:23 pm

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	IS/ACCOUNTING/ MARKETING (ACCUM. COST)	Reconciliation	
		1.00	2.00	4.00	5A.01	5.01	5A.02	
1.00	Administrative and General	0	0	432,546	0	118,279	-125,365	1.00
2.00	Skilled Nursing Care	0	0	0	0	194,865	-206,540	2.00
3.00	Physical Therapy	0	0	0	0	203,780	-215,988	3.00
4.00	Occupational Therapy	0	0	0	0	55,508	-58,834	4.00
5.00	Speech Pathology	0	0	0	0	4,271	-4,527	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	37,574	-39,825	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)	0	0	432,546		614,277		20.00
21.00	Total cost to be allocated	0	0	118,279		36,802		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.273448		0.059911		22.00

	Cost Center Description	BUSINESS OFFICE & ADMITTING (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5.02	5A.03	5.03	7.00	8.00	9.00	
1.00	Administrative and General	0	0	125,365	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	206,540	0	0	0	2.00
3.00	Physical Therapy	0	0	215,988	0	0	0	3.00
4.00	Occupational Therapy	0	0	58,834	0	0	0	4.00
5.00	Speech Pathology	0	0	4,527	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	39,825	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)	0		651,079	0	0	0	20.00
21.00	Total cost to be allocated	0		49,890	0	0	0	21.00
22.00	Unit cost multiplier	0.000000		0.076627	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1327 HHA CCN: 15-7542

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

Worksheet H-2 Part II Date/Time Prepared: 5/26/2017 2:23 pm

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	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	14,552	1,765	0	661,072	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)	0	0	14,552	1,765	0	661,072	20.00
21.00	Total cost to be allocated	0	0	57,098	677	0	7,309	21.00
22.00	Unit cost multiplier	0.000000	0.000000	3.923722	0.383569	0.000000	0.011056	22.00

	Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)						
		19.00						
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: 15-1327 | HHA CCN: 15-7542 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-3 Part I | Date/Time Prepared: 5/26/2017 2:23 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	300,964		300,964	1,385	217.30	1.00
2.00	Physical Therapy	3.00	314,729	0	314,729	1,383	227.57	2.00
3.00	Occupational Therapy	4.00	85,731	0	85,731	510	168.10	3.00
4.00	Speech Pathology	5.00	6,597	0	6,597	41	160.90	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	58,032		58,032	899	64.55	6.00
7.00	Total (sum of lines 1-6)		766,053	0	766,053	4,218		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		45460	0	852			8.00
8.01	Skilled Nursing Care		99915	0	181			8.01
9.00	Physical Therapy		45460	0	838			9.00
9.01	Physical Therapy		99915	0	103			9.01
10.00	Occupational Therapy		45460	0	317			10.00
10.01	Occupational Therapy		99915	0	42			10.01
11.00	Speech Pathology		45460	0	30			11.00
11.01	Speech Pathology		99915	0	0			11.01
12.00	Medical Social Services		45460	0	0			12.00
12.01	Medical Social Services		99915	0	0			12.01
13.00	Home Health Aide		45460	0	648			13.00
13.01	Home Health Aide		99915	0	116			13.01
14.00	Total (sum of lines 8-13)			0	3,127			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	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,033		0	224,471		1.00
2.00	Physical Therapy	0	941		0	214,143		2.00
3.00	Occupational Therapy	0	359		0	60,348		3.00
4.00	Speech Pathology	0	30		0	4,827		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	764		0	49,316		6.00
7.00	Total (sum of lines 1-6)	0	3,127		0	553,105		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1327 HHA CCN: 15-7542 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-3 Part I Date/Time Prepared: 5/26/2017 2:23 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
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Cost Center Description	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	224,471	1.00
2.00	Physical Therapy	214,143	2.00
3.00	Occupational Therapy	60,348	3.00
4.00	Speech Pathology	4,827	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	49,316	6.00
7.00	Total (sum of lines 1-6)	553,105	7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1327 HHA CCN: 15-7542 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-3 Part II Date/Time Prepared: 5/26/2017 2:23 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	0.764260	0	0	col. 2, line 2.00		1.00
1.01	Physical Therapy 1	66.01	0.000000	0	0	col. 2, line 2.01		1.01
2.00	Occupational Therapy	67.00	0.630059	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	1.451014	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.113764	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.590171	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-1327 HHA CCN: 15-7542 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-4 Part I-II Date/Time Prepared: 5/26/2017 2:23 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	435,000	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	5,594	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	5,128	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	4,196	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	253	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	450,171	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	450,171	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	450,171	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	450,171	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	450,171	31.00
31.01	Sequestration adjustment (see instructions)	0	9,004	31.01
32.00	Interim payments (see instructions)	0	441,167	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: 15-1327 HHA CCN: 15-7542

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

Worksheet H-5

Date/Time Prepared: 5/26/2017 2:23 pm

Home Health Agency I

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		441,167	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		441,167	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		441,167	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00