

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 6/23/2016 6:43 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input checked="" type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input checked="" type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 6/23/2016 Time: 6:43 pm
Contractor use only	5. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input checked="" type="checkbox"/> Initial Report for this Provider CCN 9. <input checked="" type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input checked="" type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH RENSSELAER (151324) for the cost reporting period beginning 09/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____ Title

_____ Date

Cost Center Description	Title XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	264,696	561,096	0	3,113	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I						4.00
5.00 Swing bed - SNF	0	93,600	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		2,932		0	10.00
10.03 RURAL HEALTH CLINIC IV	0		15,190		0	10.03
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00 Total	0	358,296	579,218	0	3,113	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-MEDI CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151324		Period: From 09/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 6/23/2016 6:42 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1104 EAST GRACE STREET			PO Box:						1.00	
2.00	City: RENSSLAER			State: IN		Zip Code: 47978-		County: JASPER		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		FRANCSAN HEALTH RENSSLAER	151324	99915	1	02/03/2005	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		FRANCSAN HEALTH RENSSLAER	15Z324	99915		12/31/2005	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		FRANCSAN HEALTH RENSSLAER	157149	99915		05/13/1985	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice		FRANCSAN HEALTH RENSSLAER	151519	99915		03/12/1993				14.00
15.00	Hospital-Based Health Clinic - RHC		WHEATFIELD CLINIC	153990	99915		10/07/1999	N	O	N	15.00
15.03	Hospital-Based Health Clinic - RHC IV		BROOK	158502	99915		01/01/2005	N	O	N	15.03
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						09/01/2015	12/31/2015		20.00	
21.00	Type of Control (see instructions)						1			21.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(PickLe amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						0		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	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151324		Period: From 09/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 6/23/2016 6:42 pm			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00	
		Urban/Rural		S		Date of Geogr			
		1.00		2.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
		Beginning:		Ending:					
		1.00		2.00					
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					N		37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
		Y/N		Y/N					
		1.00		2.00					
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
		V		XVII		XIX			
		1.00		2.00		3.00			
		Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
		Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					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			
		1.00		2.00		3.00		4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)						0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00		0.00				61.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet S-2
Part I
Date/Time Prepared:
6/23/2016 6:42 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/(col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/(col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151324		Period: From 09/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 6/23/2016 6:42 pm	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151324		Period: From 09/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 6/23/2016 6:42 pm					
1.00											
Long Term Care Hospital PPS											
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.						N	80.00			
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.						N	81.00			
TEFRA Providers											
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.						N	85.00			
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.							86.00			
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.						N	87.00			
V XIX											
1.00 2.00											
Title V and XIX Services											
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.						N	Y	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.						N	Y	91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.							N	92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.						N	N	93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.						N	N	94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.						0.00	0.00	95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.						N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.						0.00	0.00	97.00		
Rural Providers											
105.00	Does this hospital qualify as a critical access hospital (CAH)?						Y		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)						N		106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.						N		107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.						N		108.00		
Physical Occupational Speech Respiratory											
1.00 2.00 3.00 4.00											
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						Y	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:						84,677	0	0	118.01	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 6/23/2016 6:42 pm		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02		
119.00	DO NOT USE THIS LINE			119.00		
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00		
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00		
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00		
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00		
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00		
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00		
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00		
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00		
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00		
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00		
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00		
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00		
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00		
		1.00	2.00	3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00		
142.00	Street:	PO Box:		142.00		
143.00	City:	State:	Zip Code:	143.00		
			1.00			
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00		
		1.00	2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00		
			1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N	147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N	148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N	149.00		
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151324		Period: From 09/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 6/23/2016 6:42 pm		
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
						Beginning	Ending	
						1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				09/01/2015	12/31/2015	170.00	
							1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)						N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 6/23/2016 6:42 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)	Y	09/01/2015		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)	Y			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)	N		N	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/15/2016	Y	04/15/2016
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 6/23/2016 6:42 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			Y	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.			Y	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.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			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.			N	35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	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.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE		SMT H	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMT H@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 6/23/2016 6:42 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet S-3
Part I
Date/Time Prepared:
6/23/2016 6:42 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	2,562	21,864.00	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	2,562	21,864.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	488	3,024.00	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	3,050	24,888.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.03 RURAL HEALTH CLINIC IV	88.03				0	26.03
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: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet S-3
Part I
Date/Time Prepared:
6/23/2016 6:42 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	667	11	911			1.00
2.00 HMO and other (see instructions)	39	42				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	249	0	249			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	6			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	916	11	1,166			7.00
8.00 INTENSIVE CARE UNIT	81	0	126			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	0			13.00
14.00 Total (see instructions)	997	11	1,292	0.00	88.77	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER		0	0	0.00	0.00	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	1,966	1,318	4,490	0.00	8.88	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	836	21	1,911	0.00	0.98	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	58	61	1,067	0.00	1.19	26.00
26.03 RURAL HEALTH CLINIC IV	237	405	1,537	0.00	1.24	26.03
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	101.06	27.00
28.00 Observation Bed Days		0	499			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			1			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet S-3
Part I
Date/Time Prepared:
6/23/2016 6:42 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	184	4	276	1.00
2.00 HMO and other (see instructions)			7	16		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	184	4	276	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0		0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.03 RURAL HEALTH CLINIC IV	0.00					26.03
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: 151324 Component CCN: 157149		Period: From 09/01/2015 To 12/31/2015		Worksheet S-4 Date/Time Prepared: 6/23/2016 6:42 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County	JASPER				0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	77.00	0.00	0.00	0.00	2.00
		Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week			Staff	Contract	Total
		0			1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00			0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)				0.73	0.00	4.00
5.00	Other Administrative Personnel				1.44	0.00	5.00
6.00	Direct Nursing Service				3.77	0.00	6.00
7.00	Nursing Supervisor				0.00	0.00	7.00
8.00	Physical Therapy Service				0.00	0.96	8.00
9.00	Physical Therapy Supervisor				0.00	0.00	9.00
10.00	Occupational Therapy Service				0.00	0.72	10.00
11.00	Occupational Therapy Supervisor				0.00	0.00	11.00
12.00	Speech Pathology Service				0.00	0.10	12.00
13.00	Speech Pathology Supervisor				0.00	0.00	13.00
14.00	Medical Social Service				0.02	0.00	14.00
15.00	Medical Social Service Supervisor				0.00	0.00	15.00
16.00	Home Health Aide				2.86	0.00	16.00
17.00	Home Health Aide Supervisor				0.00	0.00	17.00
18.00	Other (specify)				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).	23844					20.00
20.01		50031					20.01
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	2.00	3.00	4.00	5.00
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	599	66	18	0	683	21.00
22.00	Skilled Nursing Visit Charges	79,667	8,778	2,394	0	90,839	22.00
23.00	Physical Therapy Visits	497	7	6	0	510	23.00
24.00	Physical Therapy Visit Charges	71,568	1,008	864	0	73,440	24.00
25.00	Occupational Therapy Visits	139	2	2	0	143	25.00
26.00	Occupational Therapy Visit Charges	20,016	288	288	0	20,592	26.00
27.00	Speech Pathology Visits	14	0	0	0	14	27.00
28.00	Speech Pathology Visit Charges	2,170	0	0	0	2,170	28.00
29.00	Medical Social Service Visits	3	0	0	0	3	29.00
30.00	Medical Social Service Visit Charges	621	0	0	0	621	30.00
31.00	Home Health Aide Visits	545	66	2	0	613	31.00
32.00	Home Health Aide Visit Charges	34,335	4,158	126	0	38,619	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,797	141	28	0	1,966	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)	208,377	14,232	3,672	0	226,281	35.00
36.00	Total Number of Episodes (standard/non outlier)	73		12	0	85	36.00
37.00	Total Number of Outlier Episodes		3		0	3	37.00
38.00	Total Non-Routine Medical Supply Charges	10,082	985	0	0	11,067	38.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 151324 Component CCN: 153990		Period: From 09/01/2015 To 12/31/2015		Worksheet S-8 Date/Time Prepared: 6/23/2016 6:42 pm	
				Rural Health Clinic (RHC) I		Cost	
1.00							
Clinic Address and Identification							
1.00 Street		492 S BIERMA ST				1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00 City, State, ZIP Code, County		WHEATFIELD		IN		47978	
1.00							
3.00 FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0	
		Grant Award		Date			
		1.00		2.00			
Source of Federal Funds							
4.00 Community Health Center (Section 330(d), PHS Act)				0		4.00	
5.00 Migrant Health Center (Section 329(d), PHS Act)				0		5.00	
6.00 Health Services for the Homeless (Section 340(d), PHS Act)				0		6.00	
7.00 Appalachian Regional Commission				0		7.00	
8.00 Look-Alikes				0		8.00	
9.00 OTHER (SPECIFY)				0		9.00	
9.01				0		9.01	
9.02				0		9.02	
9.03				0		9.03	
9.04				0		9.04	
9.05				0		9.05	
9.06				0		9.06	
9.07				0		9.07	
9.08				0		9.08	
9.09				0		9.09	
9.10				0		9.10	
1.00							
10.00 Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N				0	
		Sunday		Monday		Tuesday	
		from to		from to		from	
		1.00 2.00		3.00 4.00		5.00	
11.00 Facility hours of operations (1)				08:00 17:00		08:00	
11.00 Clinic							
1.00							
12.00 Have you received an approval for an exception to the productivity standard?		N				12.00	
13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N				0	
		Provider name		CCN number			
		1.00		2.00			
14.00 Provider name, CCN number						14.00	
		Y/N		V		XVIII	
		1.00		2.00		3.00	
						XIX	
						Total Visits	
						5.00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 151324 Component CCN: 153990		Period: From 09/01/2015 To 12/31/2015		Worksheet S-8 Date/Time Prepared: 6/23/2016 6:42 pm	
				Rural Health Clinic (RHC) I		Cost	
		County 4.00					
2.00	City, State, ZIP Code, County	JASPER				2.00	
		Tuesday		Wednesday		Thursday	
		to		from to		from to	
		6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)							
11.00	Clinic	17:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from to		from to			
		11.00 12.00		13.00 14.00			
Facility hours of operations (1)							
11.00	Clinic	08:00	17:00				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 151324 Component CCN: 158502		Period: From 09/01/2015 To 12/31/2015		Worksheet S-8 Date/Time Prepared: 6/23/2016 6:42 pm	
				Rural Health Clinic (RHC) IV		Cost	
1.00							
Clinic Address and Identification							
1.00 Street		420 E MAIN ST				1.00	
		City		State		ZIP Code	
2.00 City, State, ZIP Code, County		BROOK		IN		47922	
1.00							
3.00 FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban							
0							
3.00							
Grant Award							
Date							
1.00							
2.00							
Source of Federal Funds							
4.00 Community Health Center (Section 330(d), PHS Act)				0		4.00	
5.00 Migrant Health Center (Section 329(d), PHS Act)				0		5.00	
6.00 Health Services for the Homeless (Section 340(d), PHS Act)				0		6.00	
7.00 Appalachian Regional Commission				0		7.00	
8.00 Look-Alikes				0		8.00	
9.00 OTHER (SPECIFY)				0		9.00	
9.01				0		9.01	
9.02				0		9.02	
9.03				0		9.03	
9.04				0		9.04	
9.05				0		9.05	
9.06				0		9.06	
9.07				0		9.07	
9.08				0		9.08	
9.09				0		9.09	
9.10				0		9.10	
1.00							
2.00							
10.00 Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N				0	
		Sunday		Monday		Tuesday	
		from to		from to		from	
		1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)							
11.00 Clinic		08:00		17:00		08:00	
1.00							
2.00							
12.00 Have you received an approval for an exception to the productivity standard?		N				12.00	
13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N				0	
12.00							
13.00							
Provider name							
CCN number							
1.00							
2.00							
14.00 Provider name, CCN number							
		Y/N		V		XVIII	
		1.00		2.00		3.00	
						XIX	
						4.00	
						5.00	
						Total Visits	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							
15.00							

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 151324 Component CCN: 158502		Period: From 09/01/2015 To 12/31/2015		Worksheet S-8 Date/Time Prepared: 6/23/2016 6:42 pm	
				Rural Health Clinic (RHC) IV		Cost	
		County 4.00					
2.00	City, State, ZIP Code, County	JASPER				2.00	
		Tuesday		Wednesday		Thursday	
		to		from to		from to	
		6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)							
11.00	Clinic	17:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from to		from to			
		11.00 12.00		13.00 14.00			
Facility hours of operations (1)							
11.00	Clinic	08:00	17:00				11.00

HOSPITAL IDENTIFICATION DATA

Provider CCN: 151324
Component CCN: 151519

Period:
From 09/01/2015
To 12/31/2015

Worksheet S-9
Parts I & II
Date/Time Prepared:
6/23/2016 6:42 pm

		Hospice I						
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
PART I - ENROLLMENT DAYS								
1.00	Continuous Home Care	0	21	0	0	0	21	1.00
2.00	Routine Home Care	824	0	65	122	1,046	1,870	2.00
3.00	Inpatient Respite Care	12	0	0	0	8	20	3.00
4.00	General Inpatient Care	0	0	0	0	0	0	4.00
5.00	Total Hospice Days	836	21	65	122	1,054	1,911	5.00
Part II - CENSUS DATA								
6.00	Number of Patients Receiving Hospice Care	28	2	0	0	2	32	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	29.86	10.50	0.00	0.00	527.00	59.72	8.00
9.00	Unduplicated Census Count	29	2	0	0	2	33	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet S-10 Date/Time Prepared: 6/23/2016 6:42 pm
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.793866	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		204,261	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		653,942	5.00
6.00	Medicaid charges		1,032,360	6.00
7.00	Medicaid cost (line 1 times line 6)		819,556	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)		0	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
			1.00	
			2.00	
			3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	43,637	0	43,637
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	34,642	0	34,642
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	34,642	0	34,642
			1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,045,969	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		82,348	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		963,621	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		764,986	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		799,628	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		799,628	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet A
Date/Time Prepared:
6/23/2016 6:42 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT		1,429,814	1,429,814	23,953	1,453,767	1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	1,560,109	1,560,109	0	1,560,109	4.00
5.00 00500 ADMIN STRATIVE & GENERAL	932,492	1,409,684	2,342,176	-37,890	2,304,286	5.00
7.00 00700 OPERATION OF PLANT	92,363	192,342	284,705	0	284,705	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	19,667	12,561	32,228	0	32,228	8.00
9.00 00900 HOUSEKEEPING	129,012	27,646	156,658	0	156,658	9.00
10.00 01000 DIETARY	110,285	81,791	192,076	-103,307	88,769	10.00
11.00 01100 CAFETERIA	0	0	0	103,307	103,307	11.00
13.00 01300 NURSING ADMINISTRATION	37,324	0	37,324	0	37,324	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	5,177	3,801	8,978	0	8,978	14.00
15.00 01500 PHARMACY	116,597	728,606	845,203	0	845,203	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	85,626	22,756	108,382	0	108,382	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	20,072	20,072	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	336,110	31,722	367,832	-7,098	360,734	30.00
31.00 03100 INTENSIVE CARE UNIT	219,822	6,849	226,671	-2,094	224,577	31.00
41.00 04100 SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	174,860	370,207	545,067	-89	544,978	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	397,741	337,549	735,290	-16,210	719,080	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	223,097	349,979	573,076	-20,338	552,738	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	24,444	24,444	0	24,444	63.00
65.00 06500 RESPIRATORY THERAPY	282,244	27,639	309,883	-496	309,387	65.00
66.00 06600 PHYSICAL THERAPY	438,100	41,538	479,638	-239,727	239,911	66.00
66.01 06601 KV HEALTH PT	0	0	0	180,187	180,187	66.01
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	119,197	119,197	67.00
67.01 06701 KV HEALTH OT	0	0	0	44,140	44,140	67.01
68.00 06800 SPEECH PATHOLOGY	0	0	0	83,264	83,264	68.00
68.01 06801 KV HEALTH ST	0	0	0	27,424	27,424	68.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	67,067	67,067	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	14,325	14,325	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	63,936	45,785	109,721	0	109,721	88.00
88.03 08801 RURAL HEALTH CLINIC IV	73,461	40,305	113,766	0	113,766	88.03
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	195,926	75,200	271,126	-40,521	230,605	90.00
91.00 09100 EMERGENCY	303,499	331,213	634,712	-14,884	619,828	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	485,102	110,553	595,655	-57,999	537,656	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600 HOSPICE	0	65,455	65,455	57,999	123,454	116.00
118.00	4,722,441	7,327,548	12,049,989	200,282	12,250,271	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 RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 ALTERNACARE	164,220	8,363	172,583	0	172,583	194.00
194.01 07951 DME EQUIPMENT	0	0	0	0	0	194.01
194.02 07952 KV HEALTH CENTER	236,984	67,173	304,157	-214,485	89,672	194.02
194.03 07957 ST. JOE HEALTH CENTER	49,041	16,980	66,021	0	66,021	194.03
194.04 07953 FOUNDATION	0	0	0	0	0	194.04
194.05 07954 MEALS ON WHEELS	0	0	0	0	0	194.05
194.06 07955 WATER LAB	0	0	0	20,338	20,338	194.06
194.07 07956 ADVERTISING	0	44,743	44,743	-6,135	38,608	194.07
200.00	5,172,686	7,464,807	12,637,493	0	12,637,493	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet A
Date/Time Prepared:
6/23/2016 6:42 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	-94,208	1,359,559	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	93,161	1,653,270	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,363,319	3,667,605	5.00
7.00	00700	OPERATION OF PLANT	55,598	340,303	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	32,228	8.00
9.00	00900	HOUSEKEEPING	0	156,658	9.00
10.00	01000	DIETARY	-16,845	71,924	10.00
11.00	01100	CAFETERIA	0	103,307	11.00
13.00	01300	NURSING ADMINISTRATION	49,043	86,367	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,978	14.00
15.00	01500	PHARMACY	-7,585	837,618	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,426	104,956	16.00
17.00	01700	SOCIAL SERVICE	0	20,072	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-4,050	356,684	30.00
31.00	03100	INTENSIVE CARE UNIT	-750	223,827	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-163,698	381,280	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	719,080	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	552,738	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	24,444	63.00
65.00	06500	RESPIRATORY THERAPY	0	309,387	65.00
66.00	06600	PHYSICAL THERAPY	-670	239,241	66.00
66.01	06601	KV HEALTH PT	0	180,187	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	119,197	67.00
67.01	06701	KV HEALTH OT	0	44,140	67.01
68.00	06800	SPEECH PATHOLOGY	0	83,264	68.00
68.01	06801	KV HEALTH ST	0	27,424	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-82	66,985	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	14,325	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-1,605	108,116	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	113,766	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-22,645	207,960	90.00
91.00	09100	EMERGENCY	-575	619,253	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	537,656	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	123,454	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,244,982	13,495,253	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	ALTERNACARE	0	172,583	194.00
194.01	07951	DME EQUIPMENT	0	0	194.01
194.02	07952	KV HEALTH CENTER	0	89,672	194.02
194.03	07957	ST. JOE HEALTH CENTER	0	66,021	194.03
194.04	07953	FOUNDATION	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	194.05
194.06	07955	WATER LAB	0	20,338	194.06
194.07	07956	ADVERTISING	0	38,608	194.07
200.00		TOTAL (SUM OF LINES 118-199)	1,244,982	13,882,475	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	59,316	43,991	1.00
	O		59,316	43,991	
B - HOSPICE					
1.00	HOSPICE	116.00	57,999	0	1.00
	O		57,999	0	
C - CHARGEABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	81,392	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	O		0	81,392	
D - KV CENTER RECLASS					
1.00	KV HEALTH PT	66.01	140,394	39,793	1.00
2.00	KV HEALTH OT	67.01	34,392	9,748	2.00
3.00	KV HEALTH ST	68.01	21,368	6,056	3.00
	O		196,154	55,597	
E - ADVERTISING					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,135	1.00
	O		0	6,135	
F - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	23,953	1.00
	O		0	23,953	
G - REHAB RECLASS					
1.00	OCCUPATIONAL THERAPY	67.00	115,354	3,843	1.00
2.00	SPEECH PATHOLOGY	68.00	80,580	2,684	2.00
3.00	KV HEALTH CENTER	194.02	36,065	1,201	3.00
	O		231,999	7,728	
H - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	14,325	1.00
	O		0	14,325	
I - SOCIAL SERVICE RECLASS					
1.00	SOCIAL SERVICE	17.00	20,072	0	1.00
	O		20,072	0	
J - WATER LAB RECLASS					
1.00	WATER LAB	194.06	14,155	6,183	1.00
	TOTALS		14,155	6,183	
500.00	Grand Total: Increases		579,695	239,304	500.00

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	59,316	43,991	0		1.00
	O		59,316	43,991			
B - HOSPICE							
1.00	HOME HEALTH AGENCY	101.00	57,999	0	0		1.00
	O		57,999	0			
C - CHARGEABLE SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00	0	7,098	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	2,094	0		2.00
3.00	OPERATING ROOM	50.00	0	89	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	16,210	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	496	0		5.00
6.00	CLINIC	90.00	0	40,521	0		6.00
7.00	EMERGENCY	91.00	0	14,884	0		7.00
	O		0	81,392			
D - KV CENTER RECLASS							
1.00	KV HEALTH CENTER	194.02	196,154	55,597	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	O		196,154	55,597			
E - ADVERTISING							
1.00	ADVERTISING	194.07	0	6,135	0		1.00
	O		0	6,135			
F - PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	23,953	12		1.00
	O		0	23,953			
G - REHAB RECLASS							
1.00	PHYSICAL THERAPY	66.00	231,999	7,728	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	O		231,999	7,728			
H - IMPLANTABLE DEVICES							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	14,325	0		1.00
	O		0	14,325			
I - SOCIAL SERVICE RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	20,072	0	0		1.00
	O		20,072	0			
J - WATER LAB RECLASS							
1.00	LABORATORY	60.00	14,155	6,183	0		1.00
	TOTALS		14,155	6,183			
500.00	Grand Total: Decreases		579,695	239,304			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet A-7
Part I
Date/Time Prepared:
6/23/2016 6:42 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	53,965	621,826	0	621,826	0	1.00
2.00	Land Improvements	1,188,982	0	0	0	679,057	2.00
3.00	Buildings and Fixtures	15,561,532	1,162,381	0	1,162,381	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	4,522,915	0	0	0	47,639	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	21,327,394	1,784,207	0	1,784,207	726,696	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	21,327,394	1,784,207	0	1,784,207	726,696	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	675,791	0				1.00
2.00	Land Improvements	509,925	0				2.00
3.00	Buildings and Fixtures	16,723,913	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	4,475,276	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	22,384,905	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	22,384,905	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet A-7
Part II
Date/Time Prepared:
6/23/2016 6:42 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,134,216	1,813	293,785	0	0	1.00
3.00	Total (sum of lines 1-2)	1,134,216	1,813	293,785	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,429,814				1.00
3.00	Total (sum of lines 1-2)	0	1,429,814				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet A-7
Part III
Date/Time Prepared:
6/23/2016 6:42 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	22,384,905	0	22,384,905	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	22,384,905	0	22,384,905	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,137,029	1,813	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,137,029	1,813	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	32,627	23,953	0	164,137	1,359,559	1.00
3.00	Total (sum of lines 1-2)	32,627	23,953	0	164,137	1,359,559	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet A-8

Date/Time Prepared:
6/23/2016 6:42 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2		0			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	1,889,057				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests			0		0.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-3,426		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 WELLNESS PROGRAM FEE	B	-670		PHYSICAL THERAPY	66.00	0	33.00

Provider CCN: 151324

Period:
 From 09/01/2015
 To 12/31/2015

Worksheet A-8

Date/Time Prepared:
 6/23/2016 6:42 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
	1.00	2.00	3.00	4.00	5.00	
34.00 MEALS ON WHEELS	B	-16,845	DIETARY	10.00	0	34.00
35.00 MISCELLANEOUS INCOME BENEFITS	B	-11,642	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
36.00 MISCELLANEOUS INCOME ADMIN	B	-127,086	ADMINISTRATIVE & GENERAL	5.00	0	36.00
38.00 MISCELLANEOUS INCOME PHARMACY	B	-25,781	PHARMACY	15.00	0	38.00
39.00 MISCELLANEOUS SUPPLIES	B	-82	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	39.00
40.00 MISCELLANEOUS INCOME CLINIC	B	-1,605	RURAL HEALTH CLINIC	88.00	0	40.00
41.00 MISCELLANEOUS INCOME CARE	B	-21,395	CLINIC	90.00	0	41.00
42.00 HEALTH SCREENING	A	-486	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	42.00
43.00 INTEREST EXPENSE	A	-263,187	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	43.00
45.01 ANESTHESIA OFFSET	A	-4,050	ADULTS & PEDIATRICS	30.00	0	45.01
45.02 ANESTHESIA OFFSET	A	-750	INTENSIVE CARE UNIT	31.00	0	45.02
45.03 ANESTHESIA OFFSET	A	-163,698	OPERATING ROOM	50.00	0	45.03
45.04 ANESTHESIA OFFSET	A	-1,250	CLINIC	90.00	0	45.04
45.05 ANESTHESIA OFFSET	A	-575	EMERGENCY	91.00	0	45.05
45.06 DEPRECIATION CARRYFORWARD	A	2,813	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.06
45.08 PURCHASED SERVICES MARKETING OFFSET	A	-4,360	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09		0		0.00	0	45.09
45.10		0		0.00	0	45.10
45.11		0		0.00	0	45.11
45.12		0		0.00	0	45.12
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,244,982				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: 151324

Period: From 09/01/2015 To 12/31/2015

Worksheet A-8-1

Date/Time Prepared: 6/23/2016 6:42 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	1.00	NEW CAP REL COSTS-BLDG & FIX	FA-INT	2,029	0 1.00
2.00	1.00	NEW CAP REL COSTS-BLDG & FIX	FA-NEW CAP	164,137	0 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	FA-A&G	1,085,755	0 3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	FA-LAFAYETTE-EMP BEN	105,289	0 4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	FA-LAFAYETTE-A&G	409,010	0 4.01
4.02	7.00	OPERATION OF PLANT	FA-LAFAYETTE-PLANT	55,598	0 4.02
4.03	13.00	NURSING ADMINISTRATION	FA-LAFAYETTE-NADM	49,043	0 4.03
4.04	15.00	PHARMACY	FA-LAFAYETTE-PHARM	18,196	0 4.04
4.05	0.00			0	0 4.05
4.06	0.00			0	0 4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,889,057	0 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.

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B	FRANCISCAN ALLI	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:			0.00	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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet A-8-1

Date/Time Prepared:
6/23/2016 6:42 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	2,029	11		1.00
2.00	164,137	14		2.00
3.00	1,085,755	0		3.00
4.00	105,289	0		4.00
4.01	409,010	0		4.01
4.02	55,598	0		4.02
4.03	49,043	0		4.03
4.04	18,196	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
5.00	1,889,057			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet A-8-2

Date/Time Prepared:
6/23/2016 6:42 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	6,000	0	6,000	0	0	1.00
2.00	91.00	EMERGENCY	283,632	0	283,632	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			289,632	0	289,632	0	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	91.00	EMERGENCY	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	91.00	EMERGENCY	0	0	0	0		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	0		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151324		Period: From 09/01/2015 To 12/31/2015		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/23/2016 6:42 pm	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					18	1.00
2.00	Line 1 multiplied by 15 hours per week					270	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.51	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	484.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	79.98	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.99	39.99	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					38,710	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					38,710	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					38,710	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					38,710	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151324				Period: From 09/01/2015 To 12/31/2015		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/23/2016 6:42 pm		
		Physical Therapy				Cost				
						1.00				
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0		46.00		
		Therapists	Assistants	Aides	Trainees	Total				
		1.00	2.00	3.00	4.00	5.00				
PART V - OVERTIME COMPUTATION										
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00		
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00		
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00		
CALCULATION OF LIMIT										
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00		
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00		
DETERMINATION OF OVERTIME ALLOWANCE										
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.98	0.00	0.00	0.00			52.00		
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00		
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00		
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00		
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00		
						1.00				
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT										
57.00	Salary equivalency amount (from line 23)						38,710		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)						0		58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0		59.00	
60.00	Overtime allowance (from column 5, line 56)						0		60.00	
61.00	Equipment cost (see instructions)						0		61.00	
62.00	Supplies (see instructions)						0		62.00	
63.00	Total allowance (sum of lines 57-62)						38,710		63.00	
64.00	Total cost of outside supplier services (from your records)						26,785		64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0		65.00	
LINE 33 CALCULATION										
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						0		100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0		100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27						0		100.02	
LINE 34 CALCULATION										
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0		101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0		101.01	
101.02	Line 34 = sum of lines 27 and 31						0		101.02	
LINE 35 CALCULATION										
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0		102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0		102.01	
102.02	Line 35 = sum of lines 31 and 32						0		102.02	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet B
Part I
Date/Time Prepared:
6/23/2016 6:42 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,359,559	1,359,559				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,653,270	0	1,653,270			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,667,605	143,037	291,626	4,102,268	4,102,268	5.00
7.00 00700	OPERATION OF PLANT	340,303	23,931	29,521	393,755	165,159	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	32,228	20,738	6,286	59,252	24,853	8.00
9.00 00900	HOUSEKEEPING	156,658	24,547	41,234	222,439	93,301	9.00
10.00 01000	DIETARY	71,924	22,533	16,290	110,747	46,452	10.00
11.00 01100	CAFETERIA	103,307	26,227	18,958	148,492	62,284	11.00
13.00 01300	NURSING ADMINISTRATION	86,367	5,168	11,929	103,464	43,398	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	8,978	0	1,655	10,633	4,460	14.00
15.00 01500	PHARMACY	837,618	12,928	37,266	887,812	372,389	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	104,956	17,506	27,367	149,829	62,845	16.00
17.00 01700	SOCIAL SERVICE	20,072	1,282	6,415	27,769	11,648	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	356,684	130,891	107,426	595,001	249,571	30.00
31.00 03100	INTENSIVE CARE UNIT	223,827	9,696	70,258	303,781	127,420	31.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	381,280	147,104	55,888	584,272	245,071	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	719,080	123,427	127,124	969,631	406,708	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	552,738	31,601	66,781	651,120	273,110	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	24,444	2,565	0	27,009	11,329	63.00
65.00 06500	RESPIRATORY THERAPY	309,387	41,527	90,209	441,123	185,027	65.00
66.00 06600	PHYSICAL THERAPY	239,241	33,229	65,873	338,343	141,917	66.00
66.01 06601	KV HEALTH PT	180,187	116,771	44,872	341,830	143,379	66.01
67.00 06700	OCCUPATIONAL THERAPY	119,197	16,570	36,869	172,636	72,411	67.00
67.01 06701	KV HEALTH OT	44,140	28,612	10,992	83,744	35,126	67.01
68.00 06800	SPEECH PATHOLOGY	83,264	11,581	25,755	120,600	50,585	68.00
68.01 06801	KV HEALTH ST	27,424	17,775	6,830	52,029	21,823	68.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,985	14,402	0	81,387	34,137	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	14,325	2,090	0	16,415	6,885	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	108,116	0	20,435	128,551	53,920	88.00
88.03 08801	RURAL HEALTH CLINIC IV	113,766	33,986	23,479	171,231	71,822	88.03
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	207,960	57,546	62,621	328,127	137,632	90.00
91.00 09100	EMERGENCY	619,253	57,251	97,003	773,507	324,444	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	537,656	39,578	136,509	713,743	299,377	101.00
SPECIAL PURPOSE COST CENTERS							
116.00 11600	HOSPICE	123,454	3,193	18,537	145,184	60,897	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	13,495,253	1,217,292	1,556,008	13,255,724	3,839,380	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,950	0	2,950	1,237	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	ALTERNACARE	172,583	107,242	52,487	332,312	139,387	194.00
194.01 07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02 07952	KV HEALTH CENTER	89,672	21,315	24,577	135,564	56,862	194.02
194.03 07957	ST. JOE HEALTH CENTER	66,021	0	15,674	81,695	34,267	194.03
194.04 07953	FOUNDATION	0	0	0	0	0	194.04
194.05 07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06 07955	WATER LAB	20,338	7,105	4,524	31,967	13,408	194.06
194.07 07956	ADVERTISING	38,608	3,655	0	42,263	17,727	194.07
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet B
Part I
Date/Time Prepared:
6/23/2016 6:42 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
202.00 TOTAL (sum lines 118-201)	13,882,475	1,359,559		1,653,270	13,882,475	4,102,268	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet B
Part I
Date/Time Prepared:
6/23/2016 6:42 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
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	558,914				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,719	93,824			8.00
9.00	00900	HOUSEKEEPING	11,504	0	327,244		9.00
10.00	01000	DIETARY	10,560	0	1,607	169,366	10.00
11.00	01100	CAFETERIA	12,291	0	1,205	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,422	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	6,059	0	4,420	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,204	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	601	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	61,343	38,419	121,692	63,299	33,910
31.00	03100	INTENSIVE CARE UNIT	4,544	3,108	5,424	7,325	12,522
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	68,940	5,721	0	0	13,615
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,845	5,566	26,417	0	23,110
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	14,810	0	17,327	0	19,992
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,202	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	19,462	1,602	13,359	0	20,139
66.00	06600	PHYSICAL THERAPY	15,573	7,256	11,360	0	12,356
66.01	06601	KV HEALTH PT	54,725	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	7,766	0	5,665	0	6,693
67.01	06701	KV HEALTH OT	13,409	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	5,427	0	3,958	0	4,674
68.01	06801	KV HEALTH ST	8,331	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,750	0	0	0	1,220
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	980	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
88.03	08801	RURAL HEALTH CLINIC IV	15,928	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	26,969	5,174	0	2,109	14,365
91.00	09100	EMERGENCY	26,831	14,157	23,906	0	22,909
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	FAMILY PRACTICE	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	18,548	0	20,993	0	0
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	1,497	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	492,240	81,003	257,333	72,733	205,960
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,382	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	ALTERNACARE	50,260	12,821	66,295	80,162	16,976
194.01	07951	DME EQUIPMENT	0	0	0	0	0
194.02	07952	KV HEALTH CENTER	9,989	0	0	0	0
194.03	07957	ST. JOE HEALTH CENTER	0	0	0	0	0
194.04	07953	FOUNDATION	0	0	0	0	0
194.05	07954	MEALS ON WHEELS	0	0	0	16,471	0
194.06	07955	WATER LAB	3,330	0	3,616	0	1,336
194.07	07956	ADVERTISING	1,713	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	558,914	93,824	327,244	169,366	224,272

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

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Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
		13.00	14.00	15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
4.00	00400						4.00	
5.00	00500						5.00	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000						10.00	
11.00	01100						11.00	
13.00	01300	151,494					13.00	
14.00	01400	0	15,093				14.00	
15.00	01500	0	0	1,277,422			15.00	
16.00	01600	0	0	0	231,124		16.00	
17.00	01700	0	0	0	0	41,275	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	42,229	0	0	75,441	37,708	30.00	
31.00	03100	15,594	0	0	0	3,567	31.00	
41.00	04100	0	0	0	0	0	41.00	
42.00	04200	0	0	0	0	0	42.00	
43.00	04300	0	0	0	0	0	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	16,954	0	0	30,184	0	50.00	
52.00	05200	0	0	0	0	0	52.00	
54.00	05400	28,779	0	0	53,790	0	54.00	
57.00	05700	0	0	0	0	0	57.00	
58.00	05800	0	0	0	0	0	58.00	
59.00	05900	0	0	0	0	0	59.00	
60.00	06000	0	0	0	7,217	0	60.00	
60.01	06001	0	0	0	0	0	60.01	
63.00	06300	0	0	0	0	0	63.00	
65.00	06500	0	0	0	0	0	65.00	
66.00	06600	0	0	0	0	0	66.00	
66.01	06601	0	0	0	0	0	66.01	
67.00	06700	0	0	0	0	0	67.00	
67.01	06701	0	0	0	0	0	67.01	
68.00	06800	0	0	0	0	0	68.00	
68.01	06801	0	0	0	0	0	68.01	
70.00	07000	0	0	0	0	0	70.00	
71.00	07100	1,520	15,093	0	0	0	71.00	
72.00	07200	0	0	0	0	0	72.00	
73.00	07300	0	0	1,277,422	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	0	0	0	0	0	88.00	
88.03	08801	0	0	0	0	0	88.03	
89.00	08900	0	0	0	0	0	89.00	
90.00	09000	17,889	0	0	44,547	0	90.00	
91.00	09100	28,529	0	0	19,945	0	91.00	
92.00	09200	0	0	0	0	0	92.00	
93.00	04040	0	0	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	0	0	0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS								
116.00	11600	0	0	0	0	0	116.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)		151,494	15,093	1,277,422	231,124	41,275	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	0	0	0	0	0	190.00	
192.00	19200	0	0	0	0	0	192.00	
192.01	19201	0	0	0	0	0	192.01	
193.00	19300	0	0	0	0	0	193.00	
194.00	07950	0	0	0	0	0	194.00	
194.01	07951	0	0	0	0	0	194.01	
194.02	07952	0	0	0	0	0	194.02	
194.03	07957	0	0	0	0	0	194.03	
194.04	07953	0	0	0	0	0	194.04	
194.05	07954	0	0	0	0	0	194.05	
194.06	07955	0	0	0	0	0	194.06	
194.07	07956	0	0	0	0	0	194.07	
200.00	Cross Foot Adjustments		0	0	0	0	200.00	
201.00	Negative Cost Centers		0	0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)		151,494	15,093	1,277,422	231,124	41,275	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151324

Period:
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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
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMINISTRATIVE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPING				9.00
10.00	01000 DIETARY				10.00
11.00	01100 CAFETERIA				11.00
13.00	01300 NURSING ADMINISTRATION				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY				14.00
15.00	01500 PHARMACY				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY				16.00
17.00	01700 SOCIAL SERVICE				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	1,318,613	0	1,318,613	30.00
31.00	03100 INTENSIVE CARE UNIT	483,285	0	483,285	31.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	42.00
43.00	04300 NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	964,757	0	964,757	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,571,846	0	1,571,846	54.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	983,576	0	983,576	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	39,540	0	39,540	63.00
65.00	06500 RESPIRATORY THERAPY	680,712	0	680,712	65.00
66.00	06600 PHYSICAL THERAPY	526,805	0	526,805	66.00
66.01	06601 KV HEALTH PT	539,934	0	539,934	66.01
67.00	06700 OCCUPATIONAL THERAPY	265,171	0	265,171	67.00
67.01	06701 KV HEALTH OT	132,279	0	132,279	67.01
68.00	06800 SPEECH PATHOLOGY	185,244	0	185,244	68.00
68.01	06801 KV HEALTH ST	82,183	0	82,183	68.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	140,107	0	140,107	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	24,280	0	24,280	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,277,422	0	1,277,422	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	182,471	0	182,471	88.00
88.03	08801 RURAL HEALTH CLINIC IV	258,981	0	258,981	88.03
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	576,812	0	576,812	90.00
91.00	09100 EMERGENCY	1,234,228	0	1,234,228	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY	1,052,661	0	1,052,661	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600 HOSPICE	207,578	0	207,578	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	12,728,485	0	12,728,485	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,569	0	5,569	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
192.01	19201 RENNELAER HEALTH CENTER	0	0	0	192.01
193.00	19300 NONPAID WORKERS	0	0	0	193.00
194.00	07950 ALTERNACARE	698,213	0	698,213	194.00
194.01	07951 DME EQUIPMENT	0	0	0	194.01
194.02	07952 KV HEALTH CENTER	202,415	0	202,415	194.02
194.03	07957 ST. JOE HEALTH CENTER	115,962	0	115,962	194.03
194.04	07953 FOUNDATION	0	0	0	194.04
194.05	07954 MEALS ON WHEELS	16,471	0	16,471	194.05
194.06	07955 WATER LAB	53,657	0	53,657	194.06
194.07	07956 ADVERTISING	61,703	0	61,703	194.07
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)	13,882,475	0	13,882,475	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	143,037	143,037	0	143,037	5.00
7.00 00700	OPERATION OF PLANT	0	23,931	23,931	0	5,759	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	20,738	20,738	0	867	8.00
9.00 00900	HOUSEKEEPING	0	24,547	24,547	0	3,253	9.00
10.00 01000	DIETARY	0	22,533	22,533	0	1,620	10.00
11.00 01100	CAFETERIA	0	26,227	26,227	0	2,172	11.00
13.00 01300	NURSING ADMINISTRATION	0	5,168	5,168	0	1,513	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	156	14.00
15.00 01500	PHARMACY	0	12,928	12,928	0	12,984	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	17,506	17,506	0	2,191	16.00
17.00 01700	SOCIAL SERVICE	0	1,282	1,282	0	406	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	130,891	130,891	0	8,702	30.00
31.00 03100	INTENSIVE CARE UNIT	0	9,696	9,696	0	4,443	31.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	147,104	147,104	0	8,545	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	123,427	123,427	0	14,181	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	0	31,601	31,601	0	9,523	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	2,565	2,565	0	395	63.00
65.00 06500	RESPIRATORY THERAPY	0	41,527	41,527	0	6,451	65.00
66.00 06600	PHYSICAL THERAPY	0	33,229	33,229	0	4,948	66.00
66.01 06601	KV HEALTH PT	0	116,771	116,771	0	4,999	66.01
67.00 06700	OCCUPATIONAL THERAPY	0	16,570	16,570	0	2,525	67.00
67.01 06701	KV HEALTH OT	0	28,612	28,612	0	1,225	67.01
68.00 06800	SPEECH PATHOLOGY	0	11,581	11,581	0	1,764	68.00
68.01 06801	KV HEALTH ST	0	17,775	17,775	0	761	68.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,402	14,402	0	1,190	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	2,090	2,090	0	240	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	1,880	88.00
88.03 08801	RURAL HEALTH CLINIC IV	0	33,986	33,986	0	2,504	88.03
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	0	57,546	57,546	0	4,799	90.00
91.00 09100	EMERGENCY	0	57,251	57,251	0	11,313	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	0	39,578	39,578	0	10,438	101.00
SPECIAL PURPOSE COST CENTERS							
116.00 11600	HOSPICE	0	3,193	3,193	0	2,123	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,217,292	1,217,292	0	133,870	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,950	2,950	0	43	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201	RENSELLEAER HEALTH CENTER	0	0	0	0	0	192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	ALTERNACARE	0	107,242	107,242	0	4,860	194.00
194.01 07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02 07952	KV HEALTH CENTER	0	21,315	21,315	0	1,983	194.02
194.03 07957	ST. JOE HEALTH CENTER	0	0	0	0	1,195	194.03
194.04 07953	FOUNDATION	0	0	0	0	0	194.04
194.05 07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06 07955	WATER LAB	0	7,105	7,105	0	468	194.06
194.07 07956	ADVERTISING	0	3,655	3,655	0	618	194.07
200.00	Cross Foot Adjustments			0			200.00
201.00	Negative Cost Centers			0			201.00
202.00	TOTAL (sum lines 118-201)	0	1,359,559	1,359,559	0	143,037	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet B
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Date/Time Prepared:
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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
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	29,690				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	516	22,121			8.00
9.00	00900	HOUSEKEEPING	611	0	28,411		9.00
10.00	01000	DIETARY	561	0	140	24,854	10.00
11.00	01100	CAFETERIA	653	0	105	0	29,157
13.00	01300	NURSING ADMINISTRATION	129	0	0	0	287
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	322	0	384	0	876
16.00	01600	MEDICAL RECORDS & LIBRARY	436	0	0	0	1,332
17.00	01700	SOCIAL SERVICE	32	0	0	0	163
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,259	9,057	10,562	9,289	4,410
31.00	03100	INTENSIVE CARE UNIT	241	733	471	1,075	1,628
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,660	1,349	0	0	1,770
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,073	1,312	2,294	0	3,004
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	787	0	1,504	0	2,599
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	64	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,034	378	1,160	0	2,618
66.00	06600	PHYSICAL THERAPY	827	1,711	986	0	1,606
66.01	06601	KV HEALTH PT	2,907	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	413	0	492	0	870
67.01	06701	KV HEALTH OT	712	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	288	0	344	0	608
68.01	06801	KV HEALTH ST	443	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	359	0	0	0	159
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	52	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
88.03	08801	RURAL HEALTH CLINIC IV	846	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	1,433	1,220	0	310	1,868
91.00	09100	EMERGENCY	1,425	3,338	2,076	0	2,978
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	FAMILY PRACTICE	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	985	0	1,823	0	0
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	80	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,148	19,098	22,341	10,674	26,776
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	73	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	ALTERNACARE	2,670	3,023	5,756	11,763	2,207
194.01	07951	DME EQUIPMENT	0	0	0	0	0
194.02	07952	KV HEALTH CENTER	531	0	0	0	0
194.03	07957	ST. JOE HEALTH CENTER	0	0	0	0	0
194.04	07953	FOUNDATION	0	0	0	0	0
194.05	07954	MEALS ON WHEELS	0	0	0	2,417	0
194.06	07955	WATER LAB	177	0	314	0	174
194.07	07956	ADVERTISING	91	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	29,690	22,121	28,411	24,854	29,157

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet B
Part II
Date/Time Prepared:
6/23/2016 6:42 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	7,097					13.00
14.00	01400	0	156				14.00
15.00	01500	0	0	27,494			15.00
16.00	01600	0	0	0	21,465		16.00
17.00	01700	0	0	0	0	1,883	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,979	0	0	7,007	1,720	30.00
31.00	03100	731	0	0	0	163	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	794	0	0	2,803	0	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	1,348	0	0	4,996	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	670	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	0	0	0	0	63.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
66.01	06601	0	0	0	0	0	66.01
67.00	06700	0	0	0	0	0	67.00
67.01	06701	0	0	0	0	0	67.01
68.00	06800	0	0	0	0	0	68.00
68.01	06801	0	0	0	0	0	68.01
70.00	07000	0	0	0	0	0	70.00
71.00	07100	71	156	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	27,494	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
88.03	08801	0	0	0	0	0	88.03
89.00	08900	0	0	0	0	0	89.00
90.00	09000	838	0	0	4,137	0	90.00
91.00	09100	1,336	0	0	1,852	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		7,097	156	27,494	21,465	1,883	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07957	0	0	0	0	0	194.03
194.04	07953	0	0	0	0	0	194.04
194.05	07954	0	0	0	0	0	194.05
194.06	07955	0	0	0	0	0	194.06
194.07	07956	0	0	0	0	0	194.07
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		7,097	156	27,494	21,465	1,883	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 6/23/2016 6:42 pm
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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
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	186,876	0	186,876
31.00	03100	INTENSIVE CARE UNIT	19,181	0	19,181
41.00	04100	SUBPROVIDER - IRF	0	0	0
42.00	04200	SUBPROVIDER	0	0	0
43.00	04300	NURSERY	0	0	0
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	166,025	0	166,025
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	153,635	0	153,635
57.00	05700	CT SCAN	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0
60.00	06000	LABORATORY	46,684	0	46,684
60.01	06001	BLOOD LABORATORY	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,024	0	3,024
65.00	06500	RESPIRATORY THERAPY	53,168	0	53,168
66.00	06600	PHYSICAL THERAPY	43,307	0	43,307
66.01	06601	KV HEALTH PT	124,677	0	124,677
67.00	06700	OCCUPATIONAL THERAPY	20,870	0	20,870
67.01	06701	KV HEALTH OT	30,549	0	30,549
68.00	06800	SPEECH PATHOLOGY	14,585	0	14,585
68.01	06801	KV HEALTH ST	18,979	0	18,979
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,337	0	16,337
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,382	0	2,382
73.00	07300	DRUGS CHARGED TO PATIENTS	27,494	0	27,494
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,880	0	1,880
88.03	08801	RURAL HEALTH CLINIC IV	37,336	0	37,336
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0
90.00	09000	CLINIC	72,151	0	72,151
91.00	09100	EMERGENCY	81,569	0	81,569
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0
93.00	04040	FAMILY PRACTICE	0	0	0
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	52,824	0	52,824
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	5,396	0	5,396
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,178,929	0	1,178,929
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,066	0	3,066
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0
194.00	07950	ALTERNACARE	137,521	0	137,521
194.01	07951	DME EQUIPMENT	0	0	0
194.02	07952	KV HEALTH CENTER	23,829	0	23,829
194.03	07957	ST. JOE HEALTH CENTER	1,195	0	1,195
194.04	07953	FOUNDATION	0	0	0
194.05	07954	MEALS ON WHEELS	2,417	0	2,417
194.06	07955	WATER LAB	8,238	0	8,238
194.07	07956	ADVERTISING	4,364	0	4,364
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118-201)	1,359,559	0	1,359,559

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet B-1
Date/Time Prepared:
6/23/2016 6:42 pm

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5A	5.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	106,009					1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	5,172,686				4.00
5.00 00500 ADMINISTRATIVE & GENERAL	11,153	912,420	-4,102,268	9,780,207		5.00
7.00 00700 OPERATION OF PLANT	1,866	92,363	0	393,755	92,990	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	1,617	19,667	0	59,252	1,617	8.00
9.00 00900 HOUSEKEEPING	1,914	129,012	0	222,439	1,914	9.00
10.00 01000 DIETARY	1,757	50,969	0	110,747	1,757	10.00
11.00 01100 CAFETERIA	2,045	59,316	0	148,492	2,045	11.00
13.00 01300 NURSING ADMINISTRATION	403	37,324	0	103,464	403	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	5,177	0	10,633	0	14.00
15.00 01500 PHARMACY	1,008	116,597	0	887,812	1,008	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1,365	85,626	0	149,829	1,365	16.00
17.00 01700 SOCIAL SERVICE	100	20,072	0	27,769	100	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	10,206	336,110	0	595,001	10,206	30.00
31.00 03100 INTENSIVE CARE UNIT	756	219,822	0	303,781	756	31.00
41.00 04100 SUBPROVIDER - IIRF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	11,470	174,860	0	584,272	11,470	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	9,624	397,741	0	969,631	9,624	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	2,464	208,942	0	651,120	2,464	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	200	0	0	27,009	200	63.00
65.00 06500 RESPIRATORY THERAPY	3,238	282,244	0	441,123	3,238	65.00
66.00 06600 PHYSICAL THERAPY	2,591	206,101	0	338,343	2,591	66.00
66.01 06601 KV HEALTH PT	9,105	140,394	0	341,830	9,105	66.01
67.00 06700 OCCUPATIONAL THERAPY	1,292	115,354	0	172,636	1,292	67.00
67.01 06701 KV HEALTH OT	2,231	34,392	0	83,744	2,231	67.01
68.00 06800 SPEECH PATHOLOGY	903	80,580	0	120,600	903	68.00
68.01 06801 KV HEALTH ST	1,386	21,368	0	52,029	1,386	68.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,123	0	0	81,387	1,123	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	163	0	0	16,415	163	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	63,936	0	128,551	0	88.00
88.03 08801 RURAL HEALTH CLINIC IV	2,650	73,461	0	171,231	2,650	88.03
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	4,487	195,926	0	328,127	4,487	90.00
91.00 09100 EMERGENCY	4,464	303,499	0	773,507	4,464	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	3,086	427,103	0	713,743	3,086	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600 HOSPICE	249	57,999	0	145,184	249	116.00
118.00	94,916	4,868,375	-4,102,268	9,153,456	81,897	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	230	0	0	2,950	230	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201 RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 ALTERNACARE	8,362	164,220	0	332,312	8,362	194.00
194.01 07951 DME EQUIPMENT	0	0	0	0	0	194.01
194.02 07952 KV HEALTH CENTER	1,662	76,895	0	135,564	1,662	194.02
194.03 07957 ST. JOE HEALTH CENTER	0	49,041	0	81,695	0	194.03
194.04 07953 FOUNDATION	0	0	0	0	0	194.04
194.05 07954 MEALS ON WHEELS	0	0	0	0	0	194.05
194.06 07955 WATER LAB	554	14,155	0	31,967	554	194.06
194.07 07956 ADVERTISING	285	0	0	42,263	285	194.07
200.00						200.00
201.00						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet B-1

Date/Time Prepared:
6/23/2016 6:42 pm

Cost Center Description	1.00	4.00	5A	5.00	7.00	
	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
202.00 Cost to be allocated (per Wkst. B, Part I)	1,359,559	1,653,270		4,102,268	558,914	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	12.824939	0.319615		0.419446	6.010474	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)		0		143,037	29,690	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)		0.000000		0.014625	0.319282	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet B-1

Date/Time Prepared:
6/23/2016 6:42 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (DOLLAR VALUE)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (MAN HOURS)	
		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
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,711				8.00
9.00	00900	HOUSEKEEPING	0	32,579			9.00
10.00	01000	DIETARY	0	160	11,722		10.00
11.00	01100	CAFETERIA	0	120	0	115,970	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,143	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	440	0	3,486	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	5,298	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	650	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,205	12,115	4,381	17,535	30.00
31.00	03100	INTENSIVE CARE UNIT	421	540	507	6,475	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	775	0	0	7,040	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	754	2,630	0	11,950	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	1,725	0	10,338	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	217	1,330	0	10,414	65.00
66.00	06600	PHYSICAL THERAPY	983	1,131	0	6,389	66.00
66.01	06601	KV HEALTH PT	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	564	0	3,461	67.00
67.01	06701	KV HEALTH OT	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	394	0	2,417	68.00
68.01	06801	KV HEALTH ST	0	0	0	0	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	631	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	0	0	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	701	0	146	7,428	90.00
91.00	09100	EMERGENCY	1,918	2,380	0	11,846	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	2,090	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,974	25,619	5,034	106,501	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	RENSSELAER HEALTH CENTER	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	ALTERNACARE	1,737	6,600	5,548	8,778	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	194.01
194.02	07952	KV HEALTH CENTER	0	0	0	0	194.02
194.03	07957	ST. JOE HEALTH CENTER	0	0	0	0	194.03
194.04	07953	FOUNDATION	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	1,140	0	194.05
194.06	07955	WATER LAB	0	360	0	691	194.06
194.07	07956	ADVERTISING	0	0	0	0	194.07
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)	93,824	327,244	169,366	224,272	151,494

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet B-1

Date/Time Prepared:
6/23/2016 6:42 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (DOLLAR VALUE)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (MAN HOURS)	
		8.00	9.00	10.00	11.00	13.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	7.381323	10.044630	14.448558	1.933879	2.408298	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	22,121	28,411	24,854	29,157	7,097	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.740304	0.872065	2.120287	0.251418	0.112821	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet B-1
Date/Time Prepared:
6/23/2016 6:42 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (100% ALLOCATION)	PHARMACY (100% ALLOCATION)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
14.00	01400	100				14.00
15.00	01500	0	100			15.00
16.00	01600	0	0	32,505		16.00
17.00	01700	0	0	0	648	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	0	0	10,610	592	30.00
31.00	03100	0	0	0	56	31.00
41.00	04100	0	0	0	0	41.00
42.00	04200	0	0	0	0	42.00
43.00	04300	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	0	0	4,245	0	50.00
52.00	05200	0	0	0	0	52.00
54.00	05400	0	0	7,565	0	54.00
57.00	05700	0	0	0	0	57.00
58.00	05800	0	0	0	0	58.00
59.00	05900	0	0	0	0	59.00
60.00	06000	0	0	1,015	0	60.00
60.01	06001	0	0	0	0	60.01
63.00	06300	0	0	0	0	63.00
65.00	06500	0	0	0	0	65.00
66.00	06600	0	0	0	0	66.00
66.01	06601	0	0	0	0	66.01
67.00	06700	0	0	0	0	67.00
67.01	06701	0	0	0	0	67.01
68.00	06800	0	0	0	0	68.00
68.01	06801	0	0	0	0	68.01
70.00	07000	0	0	0	0	70.00
71.00	07100	100	0	0	0	71.00
72.00	07200	0	0	0	0	72.00
73.00	07300	0	100	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	0	0	0	0	88.00
88.03	08801	0	0	0	0	88.03
89.00	08900	0	0	0	0	89.00
90.00	09000	0	0	6,265	0	90.00
91.00	09100	0	0	2,805	0	91.00
92.00	09200	0	0	0	0	92.00
93.00	04040	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	0	0	0	0	116.00
118.00		100	100	32,505	648	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
192.01	19201	0	0	0	0	192.01
193.00	19300	0	0	0	0	193.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	0	0	0	194.02
194.03	07957	0	0	0	0	194.03
194.04	07953	0	0	0	0	194.04
194.05	07954	0	0	0	0	194.05
194.06	07955	0	0	0	0	194.06
194.07	07956	0	0	0	0	194.07
200.00						200.00
201.00						201.00
202.00		15,093	1,277,422	231,124	41,275	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet B-1

Date/Time Prepared:
6/23/2016 6:42 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (100% ALLOCATION)	PHARMACY (100% ALLOCATION)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
		14.00	15.00	16.00	17.00		
203.00	Unit cost multiplier (Wkst. B, Part I)	150.930000	12,774.220000	7.110414	63.695988		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	156	27,494	21,465	1,883		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.560000	274.940000	0.660360	2.905864		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151324		Period: From 09/01/2015 To 12/31/2015		Worksheet C Part I Date/Time Prepared: 6/23/2016 6:42 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		1,318,613		0	0	30.00
31.00	03100 INTENSIVE CARE UNIT		483,285		0	0	31.00
41.00	04100 SUBPROVIDER - I RF		0		0	0	41.00
42.00	04200 SUBPROVIDER		0		0	0	42.00
43.00	04300 NURSERY		0		0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		964,757		0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0		0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,571,846		0	0	54.00
57.00	05700 CT SCAN		0		0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0		0	0	59.00
60.00	06000 LABORATORY		983,576		0	0	60.00
60.01	06001 BLOOD LABORATORY		0		0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		39,540		0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	680,712		0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	526,805		0	0	66.00
66.01	06601 KV HEALTH PT	0	539,934		0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	265,171		0	0	67.00
67.01	06701 KV HEALTH OT	0	132,279		0	0	67.01
68.00	06800 SPEECH PATHOLOGY	0	185,244		0	0	68.00
68.01	06801 KV HEALTH ST	0	82,183		0	0	68.01
70.00	07000 ELECTROENCEPHALOGRAPHY		0		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		140,107		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		24,280		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,277,422		0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC		182,471		0	0	88.00
88.03	08801 RURAL HEALTH CLINIC IV		258,981		0	0	88.03
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0	0	89.00
90.00	09000 CLINIC		576,812		0	0	90.00
91.00	09100 EMERGENCY		1,234,228		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		396,386		0	0	92.00
93.00	04040 FAMILY PRACTICE		0		0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY		1,052,661				101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600 HOSPICE		207,578				116.00
200.00	Subtotal (see instructions)		13,124,871	0		0	200.00
201.00	Less Observation Beds		396,386				201.00
202.00	Total (see instructions)		12,728,485	0		0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 151324		Period: From 09/01/2015 To 12/31/2015		Worksheet C Part I Date/Time Prepared: 6/23/2016 6:42 pm	
			Title XVIII		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00					
9.00	10.00							
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	818,495		818,495			30.00
31.00	03100	INTENSIVE CARE UNIT	168,270		168,270			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	0		0			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	207,957	1,169,063	1,377,020	0.700612	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	194,654	2,661,137	2,855,791	0.550407	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	459,894	2,352,843	2,812,737	0.349686	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	39,655	24,772	64,427	0.613718	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	443,180	515,343	958,523	0.710168	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	54,387	385,317	439,704	1.198090	0.000000	66.00
66.01	06601	KV HEALTH PT	0	381,798	381,798	1.414188	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	38,215	112,906	151,121	1.754693	0.000000	67.00
67.01	06701	KV HEALTH OT	0	55,198	55,198	2.396446	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	6,935	34,854	41,789	4.432841	0.000000	68.00
68.01	06801	KV HEALTH ST	0	24,705	24,705	3.326574	0.000000	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,160	253,991	279,151	0.501904	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,647	33,328	42,975	0.564980	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	592,578	1,710,813	2,303,391	0.554583	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	86,766	86,766			88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	133,042	133,042			88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	41,339	779,088	820,427	0.703063	0.000000	90.00
91.00	09100	EMERGENCY	3,335	933,827	937,162	1.316985	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	8,501	512,775	521,276	0.760415	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	448,431	448,431			101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	311,343	311,343			116.00
200.00		Subtotal (see instructions)	3,112,202	12,921,340	16,033,542			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,112,202	12,921,340	16,033,542			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 6/23/2016 6:42 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
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
66.01	06601 KV HEALTH PT	0.000000		66.01
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
67.01	06701 KV HEALTH OT	0.000000		67.01
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
68.01	06801 KV HEALTH ST	0.000000		68.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO 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
88.03	08801 RURAL HEALTH CLINIC IV			88.03
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040 FAMILY PRACTICE	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet C
Part I
Date/Time Prepared:
6/23/2016 6:42 pm

		Title XIX		Hospital		Cost		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
				Total Costs	RCE Disallowance			
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,318,613		1,318,613	0	1,318,613	30.00
31.00	03100	INTENSIVE CARE UNIT	483,285		483,285	0	483,285	31.00
41.00	04100	SUBPROVIDER - I RF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	0		0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	964,757		964,757	0	964,757	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,571,846		1,571,846	0	1,571,846	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	983,576		983,576	0	983,576	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	39,540		39,540	0	39,540	63.00
65.00	06500	RESPIRATORY THERAPY	680,712	0	680,712	0	680,712	65.00
66.00	06600	PHYSICAL THERAPY	526,805	0	526,805	0	526,805	66.00
66.01	06601	KV HEALTH PT	539,934	0	539,934	0	539,934	66.01
67.00	06700	OCCUPATIONAL THERAPY	265,171	0	265,171	0	265,171	67.00
67.01	06701	KV HEALTH OT	132,279	0	132,279	0	132,279	67.01
68.00	06800	SPEECH PATHOLOGY	185,244	0	185,244	0	185,244	68.00
68.01	06801	KV HEALTH ST	82,183	0	82,183	0	82,183	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	140,107		140,107	0	140,107	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	24,280		24,280	0	24,280	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,277,422		1,277,422	0	1,277,422	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	182,471		182,471	0	182,471	88.00
88.03	08801	RURAL HEALTH CLINIC IV	258,981		258,981	0	258,981	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	576,812		576,812	0	576,812	90.00
91.00	09100	EMERGENCY	1,234,228		1,234,228	0	1,234,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	396,386		396,386	0	396,386	92.00
93.00	04040	FAMILY PRACTICE	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,052,661		1,052,661		1,052,661	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	207,578		207,578		207,578	116.00
200.00		Subtotal (see instructions)	13,124,871	0	13,124,871	0	13,124,871	200.00
201.00		Less Observation Beds	396,386		396,386		396,386	201.00
202.00		Total (see instructions)	12,728,485	0	12,728,485	0	12,728,485	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151324		Period: From 09/01/2015 To 12/31/2015		Worksheet C Part I Date/Time Prepared: 6/23/2016 6:42 pm	
		Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	818,495		818,495		30.00
31.00	03100	INTENSIVE CARE UNIT	168,270		168,270		31.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	0		0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	207,957	1,169,063	1,377,020	0.700612	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	194,654	2,661,137	2,855,791	0.550407	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	459,894	2,352,843	2,812,737	0.349686	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	39,655	24,772	64,427	0.613718	63.00
65.00	06500	RESPIRATORY THERAPY	443,180	515,343	958,523	0.710168	65.00
66.00	06600	PHYSICAL THERAPY	54,387	385,317	439,704	1.198090	66.00
66.01	06601	KV HEALTH PT	0	381,798	381,798	1.414188	66.01
67.00	06700	OCCUPATIONAL THERAPY	38,215	112,906	151,121	1.754693	67.00
67.01	06701	KV HEALTH OT	0	55,198	55,198	2.396446	67.01
68.00	06800	SPEECH PATHOLOGY	6,935	34,854	41,789	4.432841	68.00
68.01	06801	KV HEALTH ST	0	24,705	24,705	3.326574	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,160	253,991	279,151	0.501904	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,647	33,328	42,975	0.564980	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	592,578	1,710,813	2,303,391	0.554583	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	86,766	86,766	2.103024	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	133,042	133,042	1.946611	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	41,339	779,088	820,427	0.703063	90.00
91.00	09100	EMERGENCY	3,335	933,827	937,162	1.316985	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	8,501	512,775	521,276	0.760415	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	448,431	448,431		101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	311,343	311,343		116.00
200.00		Subtotal (see instructions)	3,112,202	12,921,340	16,033,542		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	3,112,202	12,921,340	16,033,542		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 6/23/2016 6:42 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
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
66.01	06601 KV HEALTH PT	0.000000		66.01
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
67.01	06701 KV HEALTH OT	0.000000		67.01
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
68.01	06801 KV HEALTH ST	0.000000		68.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO 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
88.03	08801 RURAL HEALTH CLINIC IV	0.000000		88.03
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040 FAMILY PRACTICE	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 6/23/2016 6:42 pm
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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	166,025	1,377,020	0.120568	173,456	20,913	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	153,635	2,855,791	0.053798	142,665	7,675	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	46,684	2,812,737	0.016597	278,815	4,627	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	3,024	64,427	0.046937	19,122	898	63.00
65.00	06500 RESPIRATORY THERAPY	53,168	958,523	0.055469	342,914	19,021	65.00
66.00	06600 PHYSICAL THERAPY	43,307	439,704	0.098491	28,535	2,810	66.00
66.01	06601 KV HEALTH PT	124,677	381,798	0.326552	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	20,870	151,121	0.138101	15,205	2,100	67.00
67.01	06701 KV HEALTH OT	30,549	55,198	0.553444	0	0	67.01
68.00	06800 SPEECH PATHOLOGY	14,585	41,789	0.349015	4,930	1,721	68.00
68.01	06801 KV HEALTH ST	18,979	24,705	0.768225	0	0	68.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16,337	279,151	0.058524	22,908	1,341	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2,382	42,975	0.055428	8,905	494	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	27,494	2,303,391	0.011936	257,335	3,072	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	1,880	86,766	0.021667	0	0	88.00
88.03	08801 RURAL HEALTH CLINIC IV	37,336	133,042	0.280633	0	0	88.03
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	72,151	820,427	0.087943	25,920	2,279	90.00
91.00	09100 EMERGENCY	81,569	937,162	0.087038	1,020	89	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	56,177	521,276	0.107768	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0.000000	0	0	93.00
200.00	Total (lines 50-199)	970,829	14,287,003		1,321,730	67,040	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet D
Part IV
Date/Time Prepared:
6/23/2016 6:42 pm

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
66.01	06601	KV HEALTH PT	0	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
67.01	06701	KV HEALTH OT	0	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
68.01	06801	KV HEALTH ST	0	0	0	0	0	0	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	0	0	0	0	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	0	93.00
200.00		Total (Lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 6/23/2016 6:42 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	1,377,020	0.000000	0.000000	173,456	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	2,855,791	0.000000	0.000000	142,665	54.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	2,812,737	0.000000	0.000000	278,815	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	64,427	0.000000	0.000000	19,122	63.00
65.00	06500 RESPIRATORY THERAPY	0	958,523	0.000000	0.000000	342,914	65.00
66.00	06600 PHYSICAL THERAPY	0	439,704	0.000000	0.000000	28,535	66.00
66.01	06601 KV HEALTH PT	0	381,798	0.000000	0.000000	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	151,121	0.000000	0.000000	15,205	67.00
67.01	06701 KV HEALTH OT	0	55,198	0.000000	0.000000	0	67.01
68.00	06800 SPEECH PATHOLOGY	0	41,789	0.000000	0.000000	4,930	68.00
68.01	06801 KV HEALTH ST	0	24,705	0.000000	0.000000	0	68.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	279,151	0.000000	0.000000	22,908	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	42,975	0.000000	0.000000	8,905	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,303,391	0.000000	0.000000	257,335	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	86,766	0.000000	0.000000	0	88.00
88.03	08801 RURAL HEALTH CLINIC IV	0	133,042	0.000000	0.000000	0	88.03
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	820,427	0.000000	0.000000	25,920	90.00
91.00	09100 EMERGENCY	0	937,162	0.000000	0.000000	1,020	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	521,276	0.000000	0.000000	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00
200.00	Total (lines 50-199)	0	14,287,003			1,321,730	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 6/23/2016 6:42 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
66.01	06601 KV HEALTH PT	0	0	0		66.01
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
67.01	06701 KV HEALTH OT	0	0	0		67.01
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801 KV HEALTH ST	0	0	0		68.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO 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
88.03	08801 RURAL HEALTH CLINIC IV	0	0	0		88.03
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040 FAMILY PRACTICE	0	0	0		93.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 6/23/2016 6:42 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.700612	0	447,563	0	0 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.550407	0	920,225	0	0 54.00
57.00 05700 CT SCAN	0.000000	0	0	0	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00 06000 LABORATORY	0.349686	0	1,074,769	0	0 60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.613718	0	15,174	0	0 63.00
65.00 06500 RESPIRATORY THERAPY	0.710168	0	226,953	0	0 65.00
66.00 06600 PHYSICAL THERAPY	1.198090	0	100,522	0	0 66.00
66.01 06601 KV HEALTH PT	1.414188	0	110,509	0	0 66.01
67.00 06700 OCCUPATIONAL THERAPY	1.754693	0	19,016	0	0 67.00
67.01 06701 KV HEALTH OT	2.396446	0	6,589	0	0 67.01
68.00 06800 SPEECH PATHOLOGY	4.432841	0	2,824	0	0 68.00
68.01 06801 KV HEALTH ST	3.326574	0	6,961	0	0 68.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.501904	0	63,343	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.564980	0	27,833	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.554583	0	891,035	270	0 73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0 88.00
88.03 08801 RURAL HEALTH CLINIC IV	0.000000				0 88.03
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0 89.00
90.00 09000 CLINIC	0.703063	0	379,878	440	0 90.00
91.00 09100 EMERGENCY	1.316985	0	265,674	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.760415	0	211,135	0	0 92.00
93.00 04040 FAMILY PRACTICE	0.000000	0	0	0	0 93.00
200.00 Subtotal (see instructions)		0	4,770,003	710	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	4,770,003	710	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 6/23/2016 6:42 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	313,568	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	506,498	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	375,832	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	9,313	0	63.00
65.00	06500 RESPIRATORY THERAPY	161,175	0	65.00
66.00	06600 PHYSICAL THERAPY	120,434	0	66.00
66.01	06601 KV HEALTH PT	156,281	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	33,367	0	67.00
67.01	06701 KV HEALTH OT	15,790	0	67.01
68.00	06800 SPEECH PATHOLOGY	12,518	0	68.00
68.01	06801 KV HEALTH ST	23,156	0	68.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	31,792	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	15,725	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	494,153	150	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
88.03	08801 RURAL HEALTH CLINIC IV	0	0	88.03
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	267,078	309	90.00
91.00	09100 EMERGENCY	349,889	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	160,550	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	93.00
200.00	Subtotal (see instructions)	3,047,119	459	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	3,047,119	459	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151324	Period: From 09/01/2015	Worksheet D
		Component CCN: 15Z324	To 12/31/2015	Part V
		Title XVIII		Date/Time Prepared: 6/23/2016 6:42 pm
		Swing Beds - SNF		Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.700612	0	0	0	0 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.550407	0	0	0	0 54.00
57.00 05700 CT SCAN	0.000000	0	0	0	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00 06000 LABORATORY	0.349686	0	0	0	0 60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.613718	0	0	0	0 63.00
65.00 06500 RESPIRATORY THERAPY	0.710168	0	0	0	0 65.00
66.00 06600 PHYSICAL THERAPY	1.198090	0	0	0	0 66.00
66.01 06601 KV HEALTH PT	1.414188	0	0	0	0 66.01
67.00 06700 OCCUPATIONAL THERAPY	1.754693	0	0	0	0 67.00
67.01 06701 KV HEALTH OT	2.396446	0	0	0	0 67.01
68.00 06800 SPEECH PATHOLOGY	4.432841	0	0	0	0 68.00
68.01 06801 KV HEALTH ST	3.326574	0	0	0	0 68.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.501904	0	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.564980	0	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.554583	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0 88.00
88.03 08801 RURAL HEALTH CLINIC IV	0.000000				0 88.03
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0 89.00
90.00 09000 CLINIC	0.703063	0	0	0	0 90.00
91.00 09100 EMERGENCY	1.316985	0	0	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.760415	0	0	0	0 92.00
93.00 04040 FAMILY PRACTICE	0.000000	0	0	0	0 93.00
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: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 6/23/2016 6:42 pm
		Component CCN: 15Z324		
		Title XVIII	Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
66.01	06601	KV HEALTH PT	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
67.01	06701	KV HEALTH OT	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
68.01	06801	KV HEALTH ST	0	0	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO 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
88.03	08801	RURAL HEALTH CLINIC IV	0	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	93.00
200.00		Subtotal (see instructions)	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	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 6/23/2016 6:42 pm
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,665	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,410	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)		911	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		249	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		6	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)		667	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)		249	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		129.14	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)		1,318,613	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)		775	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)		198,571	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,120,042	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)		1,120,042	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)		794.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		529,838	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)		529,838	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324		Period: From 09/01/2015 To 12/31/2015		Worksheet D-1	
		Title XVIII		Hospital		Date/Time Prepared: 6/23/2016 6:42 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	483,285	126	3,835.60	81	310,684	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)					814,340	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,654,862	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)					197,796	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)					197,796	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)					499	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					794.36	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					396,386	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324		Period: From 09/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 6/23/2016 6:42 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	186,876	1,318,613	0.141722	396,386	56,177	90.00
91.00	Nursing School cost	0	1,318,613	0.000000	396,386	0	91.00
92.00	Allied health cost	0	1,318,613	0.000000	396,386	0	92.00
93.00	All other Medical Education	0	1,318,613	0.000000	396,386	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 6/23/2016 6:42 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,665	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,410	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)		911	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		249	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		6	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)		11	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,318,613	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)		775	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)		198,571	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,120,042	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)		1,120,042	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)		794.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,738	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)		8,738	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324		Period: From 09/01/2015 To 12/31/2015		Worksheet D-1	
Title XIX		Hospital		Cost		Date/Time Prepared: 6/23/2016 6:42 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	483,285	126	3,835.60	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					14,441		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					23,179		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)						499	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						794.36	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						396,386	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324		Period: From 09/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 6/23/2016 6:42 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	186,876	1,318,613	0.141722	396,386	56,177	90.00
91.00	Nursing School cost	0	1,318,613	0.000000	396,386	0	91.00
92.00	Allied health cost	0	1,318,613	0.000000	396,386	0	92.00
93.00	All other Medical Education	0	1,318,613	0.000000	396,386	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 6/23/2016 6:42 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		493,973	30.00
31.00	03100	INTENSIVE CARE UNIT		105,300	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.700612	173,456	121,525 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.550407	142,665	78,524 54.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.349686	278,815	97,498 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.613718	19,122	11,736 63.00
65.00	06500	RESPIRATORY THERAPY	0.710168	342,914	243,527 65.00
66.00	06600	PHYSICAL THERAPY	1.198090	28,535	34,187 66.00
66.01	06601	KV HEALTH PT	1.414188	0	0 66.01
67.00	06700	OCCUPATIONAL THERAPY	1.754693	15,205	26,680 67.00
67.01	06701	KV HEALTH OT	2.396446	0	0 67.01
68.00	06800	SPEECH PATHOLOGY	4.432841	4,930	21,854 68.00
68.01	06801	KV HEALTH ST	3.326574	0	0 68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.501904	22,908	11,498 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.564980	8,905	5,031 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.554583	257,335	142,714 73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
88.03	08801	RURAL HEALTH CLINIC IV	0.000000		0 88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
90.00	09000	CLINIC	0.703063	25,920	18,223 90.00
91.00	09100	EMERGENCY	1.316985	1,020	1,343 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.760415	0	0 92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0 93.00
200.00		Total (sum of lines 50-94 and 96-98)		1,321,730	814,340 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		1,321,730	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet D-3	
		Component CCN: 15Z324		Date/Time Prepared: 6/23/2016 6:42 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
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.700612	2,050	1,436 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.550407	7,007	3,857 54.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.349686	33,518	11,721 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.613718	2,022	1,241 63.00
65.00	06500	RESPIRATORY THERAPY	0.710168	93,768	66,591 65.00
66.00	06600	PHYSICAL THERAPY	1.198090	20,910	25,052 66.00
66.01	06601	KV HEALTH PT	1.414188	0	0 66.01
67.00	06700	OCCUPATIONAL THERAPY	1.754693	18,650	32,725 67.00
67.01	06701	KV HEALTH OT	2.396446	0	0 67.01
68.00	06800	SPEECH PATHOLOGY	4.432841	1,230	5,452 68.00
68.01	06801	KV HEALTH ST	3.326574	0	0 68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.501904	866	435 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.564980	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.554583	60,060	33,308 73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
88.03	08801	RURAL HEALTH CLINIC IV	0.000000		0 88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
90.00	09000	CLINIC	0.703063	273	192 90.00
91.00	09100	EMERGENCY	1.316985	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.760415	0	0 92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0 93.00
200.00		Total (sum of lines 50-94 and 96-98)		240,354	182,010 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		240,354	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 6/23/2016 6:42 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		12,616	30.00
31.00	03100	INTENSIVE CARE UNIT		2,819	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.700612	356	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.550407	1,195	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.349686	8,360	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.613718	46	63.00
65.00	06500	RESPIRATORY THERAPY	0.710168	5,775	65.00
66.00	06600	PHYSICAL THERAPY	1.198090	748	66.00
66.01	06601	KV HEALTH PT	1.414188	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	1.754693	0	67.00
67.01	06701	KV HEALTH OT	2.396446	0	67.01
68.00	06800	SPEECH PATHOLOGY	4.432841	0	68.00
68.01	06801	KV HEALTH ST	3.326574	0	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.501904	217	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.564980	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.554583	7,478	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2.103024	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	1.946611	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.703063	568	90.00
91.00	09100	EMERGENCY	1.316985	555	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.760415	263	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		25,561	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)		25,561	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 6/23/2016 6:42 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			3,047,578 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)			3,047,578 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			3,078,054 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)			2,720 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			754,714 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)			2,320,620 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)			2,320,620 30.00
31.00	Primary payer payments			1,352 31.00
32.00	Subtotal (line 30 minus line 31)			2,319,268 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)			108,754 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			70,690 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			106,842 36.00
37.00	Subtotal (see instructions)			2,389,958 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			2,389,958 40.00
40.01	Sequestration adjustment (see instructions)			47,799 40.01
41.00	Interim payments			1,781,063 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			561,096 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: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet E-1
Part I
Date/Time Prepared:
6/23/2016 6:42 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		1,229,081		1,781,063	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)		1,229,081		1,781,063	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		264,696		561,096	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,493,777		2,342,159	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: 151324
Component CCN: 15Z324

Period:
From 09/01/2015
To 12/31/2015

Worksheet E-1
Part I
Date/Time Prepared:
6/23/2016 6:42 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		281,251		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)		281,251		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		93,600		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		374,851		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: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet E-1
Part II
Date/Time Prepared:
6/23/2016 6:42 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	277	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	748	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	39	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,038	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	16,390,934	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	0	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: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet E-2
		Component CCN: 15Z324		Date/Time Prepared: 6/23/2016 6:42 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)		199,774	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)		183,830	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		249	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)		383,604	0 8.00
9.00	Primary payer payments (see instructions)		0	0 9.00
10.00	Subtotal (line 8 minus line 9)		383,604	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)		383,604	0 12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		1,103	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)		382,501	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)		382,501	0 19.00
19.01	Sequestration adjustment (see instructions)		7,650	0 19.01
20.00	Interim payments		281,251	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)		93,600	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: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet E-3 Part V Date/Time Prepared: 6/23/2016 6:42 pm
		Title VIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			1,654,862 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)			1,654,862 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,671,411 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)			1,671,411 19.00
20.00	Deductibles (exclude professional component)			155,657 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			1,515,754 22.00
23.00	Coinsurance			3,150 23.00
24.00	Subtotal (line 22 minus line 23)			1,512,604 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			17,936 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			11,658 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			11,840 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,524,262 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)			1,524,262 30.00
30.01	Sequestration adjustment (see instructions)			30,485 30.01
31.00	Interim payments			1,229,081 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)			264,696 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: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 6/23/2016 6:42 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		23,179		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		23,179	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		23,179	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		15,435		8.00
9.00	Ancillary service charges		25,561	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		40,996	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		40,996	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		17,817	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		23,179	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		23,179	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		23,179	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		23,179	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		23,179	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)		23,179	0	40.00
41.00	Interim payments		20,066	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		3,113	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: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet G

Date/Time Prepared:
6/23/2016 6:42 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,309,117	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,701,307	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,180,930	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	402,873	0	0	0	9.00
10.00	Due from other funds	82,451	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,676,678	0	0	0	11.00
FIXED ASSETS						
12.00	Land	675,790	0	0	0	12.00
13.00	Land improvements	509,925	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	16,491,943	0	0	0	15.00
16.00	Accumulated depreciation	-1,134,216	0	0	0	16.00
17.00	Leasehold improvements	231,970	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	4,475,276	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	21,250,688	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)	27,927,366	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,139,146	0	0	0	37.00
38.00	Salaries, wages, and fees payable	699,780	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	350,000	0	0	0	43.00
44.00	Other current liabilities	863,753	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,052,679	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	19,062,232	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	580,340	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	19,642,572	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,695,251	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	5,232,115				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)	5,232,115	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	27,927,366	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet G-1

Date/Time Prepared:
6/23/2016 6:42 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		7,050,401		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-1,818,287			2.00
3.00	Total (sum of line 1 and line 2)		5,232,114		0	3.00
4.00	RECONCILING	1		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		1		0	10.00
11.00	Subtotal (line 3 plus line 10)		5,232,115		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		5,232,115		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	RECONCILING		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet G-2
Parts I & II
Date/Time Prepared:
6/23/2016 6:42 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	819,000		819,000	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	819,000		819,000	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	171,040		171,040	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)	171,040		171,040	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	990,040		990,040	17.00
18.00	Ancillary services	2,092,850	11,852,470	13,945,320	18.00
19.00	Outpatient services	297,303	582,906	880,209	19.00
20.00	RURAL HEALTH CLINIC	0	86,766	86,766	20.00
20.03	RURAL HEALTH CLINIC IV	0	133,042	133,042	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		472,667	472,667	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	311,343	311,343	26.00
27.00	PRO FEES	0	39,520	39,520	27.00
27.01	RECONCILIATION	0	551	551	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,380,193	13,479,265	16,859,458	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		12,637,493		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	FOUNDATION	20,823			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)		20,823		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		12,616,670		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151324

Period:
From 09/01/2015
To 12/31/2015

Worksheet G-3

Date/Time Prepared:
6/23/2016 6:42 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	16,859,458	1.00
2.00	Less contractual allowances and discounts on patients' accounts	6,651,218	2.00
3.00	Net patient revenues (line 1 minus line 2)	10,208,240	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	12,616,670	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,408,430	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	332	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	440,292	24.00
24.01	NA RELEASED	330,668	24.01
25.00	Total other income (sum of lines 6-24)	771,292	25.00
26.00	Total (line 5 plus line 25)	-1,637,138	26.00
27.00	OTHER EXPENSE	181,149	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	181,149	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,818,287	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151324

Period: From 09/01/2015

Worksheet H

HHA CCN: 157149

To 12/31/2015

Date/Time Prepared: 6/23/2016 6:42 pm

Home Health Agency I

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	121,497	0	55,555	0	54,998	232,050	5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	230,722	0	0	0	0	230,722	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	1,076	0	0	0	0	1,076	10.00
11.00	Home Health Aide	73,808	0	0	0	0	73,808	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	427,103	0	55,555	0	54,998	537,656	24.00
		Reclassifi cation	Reclassifi ed 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	232,050	0	232,050			5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	230,722	0	230,722			6.00
7.00	Physical Therapy	0	0	0	0			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	1,076	0	1,076			10.00
11.00	Home Health Aide	0	73,808	0	73,808			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	0	537,656	0	537,656			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: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet H-1 Part I Date/Time Prepared: 6/23/2016 6:42 pm
		HHA CCN: 157149	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
		1.00	2.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0	0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	232,050	0	0	0	232,050	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	230,722	0	0	0	230,722	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	1,076	0	0	0	1,076	10.00
11.00	Home Health Aide	73,808	0	0	0	73,808	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	537,656	0	0	0	537,656	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	232,050					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	175,190	405,912				6.00
7.00	Physical Therapy	0	0				7.00
8.00	Occupational Therapy	0	0				8.00
9.00	Speech Pathology	0	0				9.00
10.00	Medical Social Services	817	1,893				10.00
11.00	Home Health Aide	56,043	129,851				11.00
12.00	Supplies (see instructions)	0	0				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
24.00	Total (sum of lines 1-23)		537,656				24.00

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 151324 HHA CCN: 157149	Period: From 09/01/2015 To 12/31/2015	Worksheet H-1 Part II Date/Time Prepared: 6/23/2016 6:42 pm PPS
			Home Health Agency I	

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-232,050	305,606
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	230,722
7.00	Physical Therapy	0	0	0	0	0	0
8.00	Occupational Therapy	0	0	0	0	0	0
9.00	Speech Pathology	0	0	0	0	0	0
10.00	Medical Social Services	0	0	0	0	0	1,076
11.00	Home Health Aide	0	0	0	0	0	73,808
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-232,050	305,606
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		232,050
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.759311

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151324

Period: From 09/01/2015 To 12/31/2015

Worksheet H-2 Part I

HHA CCN: 157149

Date/Time Prepared: 6/23/2016 6:42 pm

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Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		NEW BLDG & FIXT						
	0	1.00		4.00	4A	5.00	7.00	
1.00 Administrative and General	0	39,578		136,509	176,087	73,859	18,548	1.00
2.00 Skilled Nursing Care	405,912	0		0	405,912	170,259	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	1,893	0		0	1,893	794	0	6.00
7.00 Home Health Aide	129,851	0		0	129,851	54,465	0	7.00
8.00 Supplies (see instructions)	0	0		0	0	0	0	8.00
9.00 Drugs	0	0		0	0	0	0	9.00
10.00 DME	0	0		0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0		0	0	0	0	11.00
12.00 Respiratory Therapy	0	0		0	0	0	0	12.00
13.00 Private Duty Nursing	0	0		0	0	0	0	13.00
14.00 Clinic	0	0		0	0	0	0	14.00
15.00 Health Promotion Activities	0	0		0	0	0	0	15.00
16.00 Day Care Program	0	0		0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0		0	0	0	0	17.00
18.00 Homemaker Service	0	0		0	0	0	0	18.00
19.00 All Others (specify)	0	0		0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	537,656	39,578		136,509	713,743	299,377	18,548	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000			21.00
Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY		
	8.00	9.00	10.00	11.00	13.00	14.00		
1.00 Administrative and General	0	20,993	0	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	0	20,993	0	0	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.								21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet H-2 Part I Date/Time Prepared: 6/23/2016 6:42 pm
		HHA CCN: 157149	Home Health Agency I	PPS

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		15.00	16.00	17.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	0	289,487	0	289,487	1.00
2.00	Skilled Nursing Care	0	0	0	576,171	0	576,171	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	2,687	0	2,687	6.00
7.00	Home Health Aide	0	0	0	184,316	0	184,316	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	1,052,661	0	1,052,661	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	218,553	794,724					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	1,019	3,706					6.00
7.00	Home Health Aide	69,915	254,231					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
20.00	Total (sum of lines 1-19) (2)	289,487	1,052,661					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.	0.379320						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: 151324
HHA CCN: 157149

Period:
From 09/01/2015
To 12/31/2015

Worksheet H-2
Part II
Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (DOLLAR VALUE)	
	NEW BLDG & FIXT (SQUARE FEET)							
	1.00	4.00						
1.00 Administrative and General	3,086		427,103	0	176,087	3,086	0	1.00
2.00 Skilled Nursing Care	0		0	0	405,912	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	1,893	0	0	6.00
7.00 Home Health Aide	0		0	0	129,851	0	0	7.00
8.00 Supplies (see instructions)	0		0	0	0	0	0	8.00
9.00 Drugs	0		0	0	0	0	0	9.00
10.00 DME	0		0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0		0	0	0	0	0	11.00
12.00 Respiratory Therapy	0		0	0	0	0	0	12.00
13.00 Private Duty Nursing	0		0	0	0	0	0	13.00
14.00 Clinic	0		0	0	0	0	0	14.00
15.00 Health Promotion Activities	0		0	0	0	0	0	15.00
16.00 Day Care Program	0		0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0		0	0	0	0	0	17.00
18.00 Homemaker Service	0		0	0	0	0	0	18.00
19.00 All Others (specify)	0		0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	3,086		427,103		713,743	3,086	0	20.00
21.00 Total cost to be allocated	39,578		136,509		299,377	18,548	0	21.00
22.00 Unit cost multiplier	12.825016		0.319616		0.419446	6.010369	0.000000	22.00
Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (MAN HOURS)	CENTRAL SERVICES & SUPPLY (100% ALLOCATION)	PHARMACY (100% ALLOCATION)		
	9.00	10.00	11.00	13.00	14.00	15.00		
1.00 Administrative and General	2,090	0	0	0	0	0	1.00	
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00 Physical Therapy	0	0	0	0	0	0	3.00	
4.00 Occupational Therapy	0	0	0	0	0	0	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	0	0	0	0	0	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19)	2,090	0	0	0	0	0	20.00	
21.00 Total cost to be allocated	20,993	0	0	0	0	0	21.00	
22.00 Unit cost multiplier	10.044498	0.000000	0.000000	0.000000	0.000000	0.000000	22.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151324
HHA CCN: 157149

Period:
From 09/01/2015
To 12/31/2015

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

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet H-3 Part I Date/Time Prepared: 6/23/2016 6:42 pm
		HHA CCN: 157149	Title XVIII	Home Health Agency I

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	794,724		794,724	1,338	593.96	1.00
2.00	Physical Therapy	3.00	0	126,461	126,461	760	166.40	2.00
3.00	Occupational Therapy	4.00	0	84,899	84,899	336	252.68	3.00
4.00	Speech Pathology	5.00	0	18,551	18,551	27	687.07	4.00
5.00	Medical Social Services	6.00	3,706		3,706	4	926.50	5.00
6.00	Home Health Aide	7.00	254,231		254,231	2,025	125.55	6.00
7.00	Total (sum of lines 1-6)		1,052,661	229,911	1,282,572	4,490		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits		Ratio (col. 3 ÷ col. 4)
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation								
8.00	Skilled Nursing Care		23844	0	652			8.00
8.01	Skilled Nursing Care		50031	0	31			8.01
9.00	Physical Therapy		23844	0	498			9.00
9.01	Physical Therapy		50031	0	12			9.01
10.00	Occupational Therapy		23844	0	141			10.00
10.01	Occupational Therapy		50031	0	2			10.01
11.00	Speech Pathology		23844	0	14			11.00
11.01	Speech Pathology		50031	0	0			11.01
12.00	Medical Social Services		23844	0	3			12.00
12.01	Medical Social Services		50031	0	0			12.01
13.00	Home Health Aide		23844	0	613			13.00
13.01	Home Health Aide		50031	0	0			13.01
14.00	Total (sum of lines 8-13)			0	1,966			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	Part A	Program Visits		Cost of Services	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
	6.00	7.00	8.00	9.00	10.00	11.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	683		0	405,675		1.00
2.00	Physical Therapy	0	510		0	84,864		2.00
3.00	Occupational Therapy	0	143		0	36,133		3.00
4.00	Speech Pathology	0	14		0	9,619		4.00
5.00	Medical Social Services	0	3		0	2,780		5.00
6.00	Home Health Aide	0	613		0	76,962		6.00
7.00	Total (sum of lines 1-6)	0	1,966		0	616,033		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151324
HHA CCN: 157149

Period:
From 09/01/2015
To 12/31/2015

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Home Health
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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
Cost Center Description		Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of col.s. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	405,675						1.00
2.00	Physical Therapy	84,864						2.00
3.00	Occupational Therapy	36,133						3.00
4.00	Speech Pathology	9,619						4.00
5.00	Medical Social Services	2,780						5.00
6.00	Home Health Aide	76,962						6.00
7.00	Total (sum of lines 1-6)	616,033						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: 151324

Period:

Worksheet H-3

HHA CCN: 157149

From 09/01/2015
To 12/31/2015

Part II
Date/Time Prepared:
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Home Health
Agency I

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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	1.198090	105,552	126,461	col. 2, line 2.00		1.00
1.01 Physical Therapy 1	66.01	1.414188	0	0	col. 2, line 2.01		1.01
2.00 Occupational Therapy	67.00	1.754693	48,384	84,899	col. 2, line 3.00		2.00
2.01 Occupational Therapy 1	67.01	2.396446	0	0	col. 2, line 3.01		2.01
3.00 Speech Pathology	68.00	4.432841	4,185	18,551	col. 2, line 4.00		3.00
3.01 Speech Pathology 1	68.01	3.326574	0	0	col. 2, line 4.01		3.01
4.00 Cost of Medical Supplies	71.00	0.501904	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.554583	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151324 HHA CCN: 157149	Period: From 09/01/2015 To 12/31/2015	Worksheet H-4 Part I-II Date/Time Prepared: 6/23/2016 6:42 pm
		Title XVII I	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	245,029
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	7,500
13.00	Total PPS Reimbursement - LUPA Episodes		0	4,174
14.00	Total PPS Reimbursement - PEP Episodes		0	0
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	1,283
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	257,986
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	257,986
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	257,986
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	257,986
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
31.00	Subtotal (see instructions)		0	257,986
31.01	Sequestration adjustment (see instructions)		0	5,160
32.00	Interim payments (see instructions)		0	252,826
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

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

Provider CCN: 151324
HHA CCN: 157149

Period: From 09/01/2015 To 12/31/2015

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Date/Time Prepared: 6/23/2016 6:42 pm
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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		252,826	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		252,826	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		252,826	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151324

Period: From 09/01/2015

Worksheet K

Hospice CCN: 151519

To 12/31/2015

Date/Time Prepared: 6/23/2016 6:42 pm

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	65,455	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	65,455	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151324

Period: From 09/01/2015

Worksheet K

Hospice CCN: 151519

To 12/31/2015

Date/Time Prepared: 6/23/2016 6:42 pm

		Hospice I					
		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	22,701	22,701	0	22,701	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	65,455	0	65,455	0	65,455	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	13,352	13,352	0	13,352	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	20,439	20,439	0	20,439	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	1,507	1,507	0	1,507	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	65,455	57,999	123,454	0	123,454	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151324

Period: From 09/01/2015

Worksheet K-4

Hospice CCN: 151519

To 12/31/2015

Part I
Date/Time Prepared:
6/23/2016 6:42 pm

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	22,701	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	65,455	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	13,352	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	20,439	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	1,507	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	123,454	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST		Provider CCN: 151324	Period: From 09/01/2015	Worksheet K-4
		Hospice CCN: 151519	To 12/31/2015	Part I
		Hospice I		Date/Time Prepared: 6/23/2016 6:42 pm

	VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col . 5A ± col . 6)	
	5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.				1.00
2.00	Capital Related Costs-Movable Equip.				2.00
3.00	Plant Operation and Maintenance				3.00
4.00	Transportation - Staff				4.00
5.00	Volunteer Service Coordination	0			5.00
6.00	Administrative and General	0	22,701	22,701	6.00
INPATIENT CARE SERVICE					
7.00	Inpatient - General Care	0	0	0	7.00
8.00	Inpatient - Respite Care	0	65,455	14,748	80,203
VISITING SERVICES					
9.00	Physician Services	0	0	0	9.00
10.00	Nursing Care	0	13,352	3,008	16,360
11.00	Nursing Care-Continuous Home Care	0	0	0	11.00
12.00	Physical Therapy	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	14.00
15.00	Medical Social Services	0	20,439	4,605	25,044
16.00	Spiritual Counseling	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	17.00
18.00	Counseling - Other	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	1,507	340	1,847
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	20.00
21.00	Other	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS					
22.00	Drugs, Biological and Infusion Therapy	0	0	0	22.00
23.00	Analgesics	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	24.00
25.00	Other - Specify	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	26.00
27.00	Patient Transportation	0	0	0	27.00
28.00	Imaging Services	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	29.00
30.00	Medical Supplies	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	32.00
33.00	Chemotherapy	0	0	0	33.00
34.00	Other	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE					
35.00	Bereavement Program Costs	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	36.00
37.00	Fundraising	0	0	0	37.00
38.00	Other Program Costs	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	123,454	123,454	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

Period: From 09/01/2015

Worksheet K-4

Hospice CCN: 151519

To 12/31/2015

Part II
Date/Time Prepared:
6/23/2016 6:42 pm

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

Period: From 09/01/2015

Worksheet K-4

Hospice CCN: 151519

To 12/31/2015

Part II
Date/Time Prepared:
6/23/2016 6:42 pm

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-22,701	100,753	6.00
INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0	7.00
8.00	Inpatient - Respite Care	0	65,455	8.00
VISITING SERVICES				
9.00	Physician Services	0	0	9.00
10.00	Nursing Care	0	13,352	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	0	12.00
13.00	Occupational Therapy	0	0	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	20,439	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	1,507	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		22,701	39.00
40.00	Unit Cost Multiplier		0.225313	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151324

Period: From 09/01/2015

Worksheet K-5

Hospice CCN: 151519

To 12/31/2015

Part I
Date/Time Prepared:
6/23/2016 6:42 pm

Cost Center Description		Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			NEW BLDG & FIXT					
			0	1.00				
1.00	Administrative and General		3,193		18,537	21,730	9,115	1.00
2.00	Inpatient - General Care	0	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	80,203	0	0	0	80,203	33,640	3.00
4.00	Physician Services	0	0	0	0	0	0	4.00
5.00	Nursing Care	16,360	0	0	0	16,360	6,862	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	25,044	0	0	0	25,044	10,505	10.00
11.00	Spiritual Counseling	0	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	1,847	0	0	0	1,847	775	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	0	19.00
20.00	Other - Specif y	0	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	123,454	3,193		18,537	145,184	60,897	34.00
35.00	Unit Cost Multiplier (see instructions)					0		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151324

Period:

Worksheet K-5

Hospice CCN: 151519

From 09/01/2015
To 12/31/2015

Part I
Date/Time Prepared:
6/23/2016 6:42 pm

Cost Center Description		Hospice I					
		OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	CAFETERIA 11.00	
1.00	Administrative and General	1,497	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	1,497	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151324

Period:

Worksheet K-5

Hospice CCN: 151519

From 09/01/2015
To 12/31/2015

Part I
Date/Time Prepared:
6/23/2016 6:42 pm

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151324

Period: From 09/01/2015

Worksheet K-5

Hospice CCN: 151519

To 12/31/2015

Part I
Date/Time Prepared:
6/23/2016 6:42 pm

Cost Center Description		Hospice I					Total Hospice Costs (cols. 26 ± 27)	
		Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)			
		24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	32,342					1.00	
2.00	Inpatient - General Care	0	0	0	0	0	2.00	
3.00	Inpatient - Respite Care	113,843	0	113,843	21,011	134,854	3.00	
4.00	Physician Services	0	0	0	0	0	4.00	
5.00	Nursing Care	23,222	0	23,222	4,286	27,508	5.00	
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00	
7.00	Physical Therapy	0	0	0	0	0	7.00	
8.00	Occupational Therapy	0	0	0	0	0	8.00	
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00	
10.00	Medical Social Services	35,549	0	35,549	6,561	42,110	10.00	
11.00	Spiritual Counseling	0	0	0	0	0	11.00	
12.00	Dietary Counseling	0	0	0	0	0	12.00	
13.00	Counseling - Other	0	0	0	0	0	13.00	
14.00	Home Health Aide and Homemaker	2,622	0	2,622	484	3,106	14.00	
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00	
16.00	Other	0	0	0	0	0	16.00	
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00	
18.00	Analgesics	0	0	0	0	0	18.00	
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00	
20.00	Other - Specify	0	0	0	0	0	20.00	
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00	
22.00	Patient Transportation	0	0	0	0	0	22.00	
23.00	Imaging Services	0	0	0	0	0	23.00	
24.00	Labs and Diagnostics	0	0	0	0	0	24.00	
25.00	Medical Supplies	0	0	0	0	0	25.00	
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00	
27.00	Radiation Therapy	0	0	0	0	0	27.00	
28.00	Chemotherapy	0	0	0	0	0	28.00	
29.00	Other	0	0	0	0	0	29.00	
30.00	Bereavement Program Costs	0	0	0	0	0	30.00	
31.00	Volunteer Program Costs	0	0	0	0	0	31.00	
32.00	Fundraising	0	0	0	0	0	32.00	
33.00	Other Program Costs	0	0	0	0	0	33.00	
34.00	Total (sum of lines 1 thru 33) (2)	207,578	0	207,578		207,578	34.00	
35.00	Unit Cost Multiplier (see instructions)				0.184563		35.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151324

Period:

Worksheet K-5

Hospice CCN: 151519

From 09/01/2015
To 12/31/2015

Part II
Date/Time Prepared:
6/23/2016 6:42 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00					
1.00 Administrative and General	249		54,031	5A	21,730	249	1.00
2.00 Inpatient - General Care	0		0		0	0	2.00
3.00 Inpatient - Respite Care	0		0		80,203	0	3.00
4.00 Physician Services	0		0		0	0	4.00
5.00 Nursing Care	0		0		16,360	0	5.00
6.00 Nursing Care-Continuous Home Care	0		0		0	0	6.00
7.00 Physical Therapy	0		0		0	0	7.00
8.00 Occupational Therapy	0		0		0	0	8.00
9.00 Speech/ Language Pathology	0		0		0	0	9.00
10.00 Medical Social Services	0		0		25,044	0	10.00
11.00 Spiritual Counseling	0		0		0	0	11.00
12.00 Dietary Counseling	0		0		0	0	12.00
13.00 Counseling - Other	0		0		0	0	13.00
14.00 Home Health Aide and Homemaker	0		0		1,847	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0		0		0	0	15.00
16.00 Other	0		0		0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0		0		0	0	17.00
18.00 Analgesics	0		0		0	0	18.00
19.00 Sedatives / Hypnotics	0		0		0	0	19.00
20.00 Other - Specify	0		0		0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0		0		0	0	21.00
22.00 Patient Transportation	0		0		0	0	22.00
23.00 Imaging Services	0		0		0	0	23.00
24.00 Labs and Diagnostics	0		0		0	0	24.00
25.00 Medical Supplies	0		0		0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0		0		0	0	26.00
27.00 Radiation Therapy	0		0		0	0	27.00
28.00 Chemotherapy	0		0		0	0	28.00
29.00 Other	0		0		0	0	29.00
30.00 Bereavement Program Costs	0		0		0	0	30.00
31.00 Volunteer Program Costs	0		0		0	0	31.00
32.00 Fundraising	0		0		0	0	32.00
33.00 Other Program Costs	0		0		0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	249		54,031		145,184	249	34.00
35.00 Total cost to be allocated	3,193		18,537		60,897	1,497	35.00
36.00 Unit Cost Multiplier (see instructions)	12.823293		0.343081		0.419447	6.012048	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151324

Period:

Worksheet K-5

Hospice CCN: 151519

From 09/01/2015

Part II

To 12/31/2015

Date/Time Prepared:

6/23/2016 6:42 pm

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151324

Period:

Worksheet K-5

Hospice CCN: 151519

From 09/01/2015
To 12/31/2015

Part II
Date/Time Prepared:
6/23/2016 6:42 pm

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

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 151324

Period: From 09/01/2015

Worksheet K-5

Hospice CCN: 151519

To 12/31/2015

Part III
Date/Time Prepared:
6/23/2016 6:42 pm

Cost Center Description		Hospice I			
		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)
		0	1.00	2.00	3.00
ANCI LLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	1.198090	0	0
1.01	KV HEALTH PT	66.01	1.414188	0	0
2.00	OCCUPATIONAL THERAPY	67.00	1.754693	0	0
2.01	KV HEALTH OT	67.01	2.396446	0	0
3.00	SPEECH PATHOLOGY	68.00	4.432841	0	0
3.01	KV HEALTH ST	68.01	3.326574	0	0
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.554583	0	0
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00			
6.00	LABORATORY	60.00	0.349686	0	0
6.01	BLOOD LABORATORY	60.01	0.000000	0	0
7.00	MEDI CAL SUPPLI ES CHARGED TO PATIENTS	71.00	0.501904	0	0
8.00	FAMI LY PRACTI CE	93.00	0.000000	0	0
9.00	RADI OLOGY-THERAPEUTI C	55.00			
10.00	OTHER ANCI LLARY SERVICE COST CENTERS	76.00			
11.00	Totals (sum of lines 1-10)				0

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 151324

Period: From 09/01/2015

Worksheet K-6

Hospice CCN: 151519

To 12/31/2015

Date/Time Prepared: 6/23/2016 6:42 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				207,578	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				1,911	2.00
3.00	Average cost per diem (line 1 divided by line 2)				108.62	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	836				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	90,806				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		21			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		2,281			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	65				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	7,060				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		122			10.00
11.00	Aggregate NF cost (line 3 times line 10)		13,252			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			1,054		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			114,485		13.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 151324 Component CCN: 153990	Period: From 09/01/2015 To 12/31/2015	Worksheet M-1 Date/Time Prepared: 6/23/2016 6:42 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	35,166	0	35,166	0	35,166	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	12,211	0	12,211	0	12,211	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	47,377	0	47,377	0	47,377	10.00
11.00	Physician Services Under Agreement	0	22,646	22,646	0	22,646	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	22,646	22,646	0	22,646	14.00
15.00	Medical Supplies	0	7,209	7,209	0	7,209	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	7,209	7,209	0	7,209	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	47,377	29,855	77,232	0	77,232	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	16,559	15,930	32,489	0	32,489	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	16,559	15,930	32,489	0	32,489	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	63,936	45,785	109,721	0	109,721	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 151324 Component CCN: 153990	Period: From 09/01/2015 To 12/31/2015	Worksheet M-1 Date/Time Prepared: 6/23/2016 6:42 pm
		Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	0
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	35,166
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	12,211
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	0
10.00	Subtotal (sum of lines 1 through 9)	0	47,377
11.00	Physician Services Under Agreement	0	22,646
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	22,646
15.00	Medical Supplies	0	7,209
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	7,209
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	77,232
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	0
30.00	Administrative Costs	-1,605	30,884
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,605	30,884
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,605	108,116

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 151324 Component CCN: 158502	Period: From 09/01/2015 To 12/31/2015	Worksheet M-1 Date/Time Prepared: 6/23/2016 6:42 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	37,182	0	37,182	0	37,182	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	28,383	0	28,383	0	28,383	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	65,565	0	65,565	0	65,565	10.00
11.00	Physician Services Under Agreement	0	22,646	22,646	0	22,646	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	22,646	22,646	0	22,646	14.00
15.00	Medical Supplies	0	9,516	9,516	0	9,516	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	9,516	9,516	0	9,516	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	65,565	32,162	97,727	0	97,727	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	7,896	8,143	16,039	0	16,039	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	7,896	8,143	16,039	0	16,039	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	73,461	40,305	113,766	0	113,766	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet M-1
	Component CCN: 158502	Rural Health Clinic (RHC) IV	Date/Time Prepared: 6/23/2016 6:42 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	37,182	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	28,383	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	65,565	10.00
11.00	Physician Services Under Agreement	0	22,646	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	22,646	14.00
15.00	Medical Supplies	0	9,516	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	9,516	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	97,727	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	16,039	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	16,039	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	113,766	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet M-2
		Component CCN: 153990		Date/Time Prepared: 6/23/2016 6:42 pm
			Rural Health Clinic (RHC) I	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.00	0	4,200	0	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.32	1,047	2,100	672	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.32	1,047		672	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.32	1,047			8.00
9.00	Physician Services Under Agreements		20			9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				77,232	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				77,232	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)				30,884	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				74,355	15.00
16.00	Total overhead (sum of lines 14 and 15)				105,239	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtotal (see instructions)				105,239	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				105,239	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				182,471	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet M-2
		Component CCN: 158502		Date/Time Prepared: 6/23/2016 6:42 pm
			Rural Health Clinic (RHC) IV	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.00	0	4,200	0	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.31	1,382	2,100	651	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.31	1,382		651	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.31	1,382			8.00
9.00	Physician Services Under Agreements		155			9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				97,727	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				97,727	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)				16,039	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				145,215	15.00
16.00	Total overhead (sum of lines 14 and 15)				161,254	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtotal (see instructions)				161,254	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				161,254	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				258,981	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet M-3
		Component CCN: 153990		Date/Time Prepared: 6/23/2016 6:42 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		182,471	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		2,322	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		180,149	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,047	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		20	5.00
6.00	Total adjusted visits (line 4 plus line 5)		1,067	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		168.84	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	168.84	168.84	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	58	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	9,793	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		9,793	16.00
16.01	Total program charges (see instructions)(from contractor's records)		4,320	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		7,720	16.04
16.05	Total program cost (see instructions)		7,720	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		143	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		835	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		7,720	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		323	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		8,043	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		8,043	26.00
26.01	Sequestration adjustment (see instructions)		161	26.01
27.00	Interim payments		4,950	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		2,932	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 151324	Period: From 09/01/2015 To 12/31/2015	Worksheet M-3
		Component CCN: 158502		Date/Time Prepared: 6/23/2016 6:42 pm
		Title XVIII	Rural Health Clinic (RHC) IV	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		258,981	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		6,220	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		252,761	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,382	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		155	5.00
6.00	Total adjusted visits (line 4 plus line 5)		1,537	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		164.45	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	164.45	164.45	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	237	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	38,975	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		38,975	16.00
16.01	Total program charges (see instructions)(from contractor's records)		17,647	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		30,242	16.04
16.05	Total program cost (see instructions)		30,242	16.05
17.00	Primary payer amounts		45	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,173	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		3,295	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		30,197	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,208	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		33,405	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		33,405	26.00
26.01	Sequestration adjustment (see instructions)		668	26.01
27.00	Interim payments		17,547	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		15,190	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 151324
Component CCN: 153990

Period:
From 09/01/2015
To 12/31/2015

Worksheet M-4
Date/Time Prepared:
6/23/2016 6:42 pm

Title XVIII

Rural Health
Clinic (RHC) I

Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	47,377	47,377	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.007063	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	335	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	648	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	983	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	77,232	77,232	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	105,239	105,239	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.012728	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	1,339	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	2,322	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	36	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	64.50	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	5	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	323	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		2,322	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		323	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 151324
Component CCN: 158502

Period:
From 09/01/2015
To 12/31/2015

Worksheet M-4
Date/Time Prepared:
6/23/2016 6:42 pm

Title XVIII
Rural Health
Clinic (RHC) IV

Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	65,565	65,565	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.002510	0.004359	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	165	286	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,368	528	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,533	814	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	97,727	97,727	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	161,254	161,254	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.015687	0.008329	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,530	1,343	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	4,063	2,157	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	19	33	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	213.84	65.36	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	15	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,208	0	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		6,220	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		3,208	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151324 Component CCN: 153990	Period: From 09/01/2015 To 12/31/2015	Worksheet M-5 Date/Time Prepared: 6/23/2016 6:42 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		4,950	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		4,950	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		2,932	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		7,882	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151324 Component CCN: 158502	Period: From 09/01/2015 To 12/31/2015	Worksheet M-5 Date/Time Prepared: 6/23/2016 6:42 pm
		Rural Health Clinic (RHC) IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		17,547	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		17,547	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		15,190	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		32,737	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00